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

DECEMBER 5, 2024
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

TELECONFERENCE LOCATION:
JW MARRIOTT PALM DESERT
74855 COUNTRY CLUB DR., ROOM #8104
PALM DESERT, CA 92260

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 Donald Wagner, Alternate

CHIEF EXECUTIVE OFFICER	OUTSIDE GENERAL COUNSEL	CLERK OF THE BOARD
Michael Hunn	James Novello Kennaday Leavitt	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://us06web.zoom.us/webinar/register/WN_oSQVYM-pT2W_qMMpi3XDyQ**
Join the Meeting.
Webinar ID: **878 0181 1561**
Passcode: **677007** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS
1. 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
2. Minutes
   a. Approve Minutes of the November 7, 2024 Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the September 19, 2024 Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee

3. Ratify the Acceptance, Receipt and Refiling of the Revised Fiscal Year 2023-24 CalOptima Health Audited Financial Statements

4. Approve Modifications to Policy GA.3400: Annual Investments

5. Approve Modifications to CalOptima Health Capitalization Policy

6. Adopt Resolution No. 24-1205-01 Liquidation and Transfer of Assets from Public Agency Retirement Services to Empower Trust Company, LLC

7. Authorize Change to Supplemental Retirement Plan Vesting Schedule

8. Adopt Resolution No. 24-1205-02 Approving and Adopting Updated CalOptima Health Human Resources Policies

9. Adopt Resolution No. 24-1205-03 Amending CalOptima Health's Conflict of Interest Code

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

11. Approve New CalOptima Health Policy AA.1251: Diversity, Equity and Inclusion Training Program

12. Approve Actions Related to a New CalOptima Health Policy GG.1668: Inpatient Interfacility Transfers

13. Receive and File:
    a. October 2024 Financial Summary
    b. Compliance Report
    c. Member Trend Report
    d. Federal and State Legislative Advocates Reports
    e. CalOptima Health Community Outreach and Program Summary
    f. Board Approved Initiatives Report – Quarter Two

REPORTS/DISCUSSION ITEMS

14. Authorize the Chief Executive Officer to Execute Contract Amendments with Collective Medical Technologies, Inc., a PointClickCare company, and Safety Net Connect, Inc. to Improve Information Exchange for Members and Providers Across Care Settings

15. Approve Actions Related to CalOptima Health Policy AA.1400: Grant Management

16. Adopt a New CalOptima Health Fiscal Year 2025-2027 Strategic Plan

17. Approve Actions Related to Covered California Consulting Support Contracts and Associated Funding

18. Authorize Unbudgeted Expenditures and Appropriate Funds in the CalOptima Health Fiscal Year 2024-25 Operating Budget for Legal Services

19. Authorize Actions Related to the Homeless Prevention and Stabilization Pilot Program

20. Approve Actions Related to the Street Medicine Program Expansion

21. Approve Actions Related to the Housing and Homelessness Incentive Program

22. Approve Actions Related to Mobile Screening Services

23. Authorize Action Related to the Medi-Cal Fee for Service Hospital Contract with University of California – Irvine – UCI Health Placentia-Linda

24. Election of Officers of the Board of Directors for Terms Beginning January 1, 2025

CLOSED SESSION

CS-1. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Government Code Section 54956.9(d)(2): 1 Case.

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 December 5, 2024 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_oSQVYM-pT2W_qMMpi3XDyQ

To **Join** this webinar:
https://us06web.zoom.us/s/87801811561?pwd=C4uiY09r2EJ2rJCvZEfFPrgatwJfbx.1

Or One tap mobile:
+16694449171,,87801811561#,,,,*677007# US
+17207072699,,87801811561#,,,,*677007# US (Denver)

Or join by phone:
Dial(for higher quality, dial a number based on your current location):
US: +1 669 444 9171 or +1 720 707 2699 or +1 253 205 0468 or +1 253 215 8782 or +1 346 248 7799 or +1 719 359 4580 or +1 646 931 3860 or +1 689 278 1000 or +1 301 715 8592 or +1 305 224 1968 or +1 309 205 3325 or +1 312 626 6799 or +1 360 209 5623 or +1 386 347 5053 or +1 507 473 4847 or +1 564 217 2000 or +1 646 558 8656

Webinar ID: 878 0181 1561
Passcode: 677007

International numbers available: **https://us06web.zoom.us/u/kkmAORWJM**

MEMORANDUM

DATE:	November 27, 2024
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — December 5, 2024, 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. State Audit Recommendations Fully Implemented; Audit Closure Now Published Online

On October 22, the California State Auditor (CSA) confirmed that CalOptima Health has fully implemented all audit recommendations and officially closed the audit with no further responses or actions required. CSA formally published the final audit status on its website here. We also distributed a press release announcing the news here.

B. Covered California Ordinance Goes to Board of Supervisors

County staff have confirmed that the Orange County Board of Supervisors (BOS) will consider amending CalOptima Health's governing ordinance to allow our participation in Covered California. The first reading of the amended ordinance is scheduled for December 3, and the second and final reading is scheduled for December 17. Staff and I are meeting with all supervisorial offices to discuss CalOptima Health's value proposition for entering Covered California in support of our members and the Orange County community.

C. CalOptima Health Hosts First Thanksgiving Meal Distribution for Members

More than 1,300 members' Thanksgiving holiday was brighter thanks to CalOptima Health's first-ever Thanksgiving meal distribution event on Saturday, November 23 at our 505 building. Members were invited via text to reserve a turkey, ham or Northgate Market gift card. Because we recognize that "food is health," and members can boost their food security by joining CalFresh, we included enrollers from the County of Orange Social Services Agency to help with applications at the event. Currently, approximately 322,000 Orange County residents are enrolled in CalFresh.

D. Election Updates

- 2024 Election Recap Includes Some Races Still Too Close to Call

  On November 5, general elections were held across the United States for federal, state, county and local offices as well as state and local ballot propositions. Many of these offices have jurisdiction over legislation, regulations or partnering agencies that impact CalOptima Health. Results are still preliminary, and a few races are still too close to call, as ballots continue to be tabulated ahead of the December 13 certification deadline by the California Secretary of State.

At the federal level, former U.S. President Donald J. Trump has been elected president, and the Republican Party has gained control of the U.S. Senate and maintained control of the U.S. House of Representatives. At the state level, Proposition 35 was approved by a wide margin to make permanent the existing Managed Care Organization (MCO) tax with strict funding allocations for Medi-Cal rate increases to a range of provider types. In addition, the Democratic Party will maintain supermajorities in both the California State Senate and California State Assembly. At the local level, the Democratic Party will maintain a majority on the Orange County Board of Supervisors.

- 2024 Signed and Vetoed State Legislation Analysis Available
  As previously shared, Gov. Gavin Newsom finished signing or vetoing legislation passed this year by the California State Legislature on September 30. Following review by staff, 12 policy bills with potential impact to CalOptima Health were signed into law, and seven were vetoed. Staff have prepared the 2024 Signed and Vetoed State Legislative Analysis (see Page 7) with both executive and full summaries of the identified bills. Next, the California Department of Health Care Services (DHCS) will release further guidance regarding the implementation of signed legislation, and the next 2025–26 legislative session will commence on December 2 with the swearing-in of newly elected and re-elected state legislators resulting from the November 5 election. Legislators will then reconvene on January 6 to begin conducting business, including authoring new legislation ahead of the February 21 bill introduction deadline.
- Presidential Transition Activity Includes Key Appointments
  President-elect Trump has nominated Robert F. Kennedy, Jr., as U.S. Secretary of Health & Human Services (HHS) and Dr. Mehmet Oz as Administrator of the Centers for Medicare & Medicaid Services (CMS), which oversees the Medicaid and Medicare programs. Both positions will be subject to confirmation by the incoming Republican-controlled U.S. Senate. CalOptima Health's federal associations and lobbyists are currently analyzing the health care policy positions of these nominees to prepare for engagement and advocacy opportunities. Relatedly, Gov. Gavin Newsom traveled to Washington, D.C., this month to meet with Biden Administration officials to advocate for urgent CMS approval of California's five pending Medicaid waiver requests — including Transitional Rent and MCO tax amendments following the recent passage of Proposition 35 — which may not be as favorably considered by the Trump Administration. Gov. Newsom also announced that he will convene a special session of the California State Legislature on the December 2 swearing-in day to bolster California's legal resources to "protect civil rights, reproductive freedom, climate action and immigrant families" in anticipation of potential actions by the incoming administration. CalOptima Health's state associations and lobbyists are monitoring any developments and outcomes.

E. DHCS Visits CalOptima Health for a Listening Session

On October 30, at the request of DHCS, CalOptima Health hosted a half-day listening session that included leadership staff, several departments from the County of Orange and external community partners. This session was a part of DHCS' listening tour across the state to better understand health plan perspectives, implementation experiences and future opportunities for Medi-Cal program reform. Specific topics discussed included Enhanced Care Management, Community Supports, Justice-Involved Initiative, Behavioral Health Transformation, Transitional Rent and data sharing. DHCS also requested to meet with several members of CalOptima Health's Member Advisory Committee and Whole Child Model Family Advisory Committee to learn about their priority areas, with a particular focus on CalAIM access and care coordination.

F. OneCare Annual Election Period Nears Closure

The annual election period (AEP) for CalOptima Health OneCare (HMO D-SNP), a Medicare Medi-Cal Plan, opened October 15 and runs 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

As you know, there are two OneCare plan options to select from for 2025:

- CalOptima Health OneCare Complete — Our original plan offers $0 copays on medical and hospital services and all covered 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 groceries, and more.
- CalOptima Health OneCare Flex Plus — Our new low-cost plan is designed for flexibility, offering $0 doctor visits and hospital stays. It also includes generous extras, such as a larger flex card allowance for OTC items, more vision care, comprehensive dental, a fitness benefit, and more.

To promote OneCare in a highly competitive Medicare Advantage marketplace, CalOptima Health launched in October a new, integrated marketing campaign with the tagline "Medicare + Medi-Cal Built Around You." It emphasizes that OneCare is the only plan in Orange County that integrates Medicare and Medi-Cal into one plan, meaning it's specifically designed for duals in our community. All campaign messaging is rooted in research from focus groups in three languages with former and prospective members as well as an additional online and phone research survey. More information is available at www.caloptima.org/OneCare.

G. Estrella Springs in Santa Ana Celebrates Grand Opening

Recently, I spoke at the Grand Opening of Estrella Springs, a permanent supportive housing development in Santa Ana. CalOptima Health contributed $4.7 million in funding through the Housing and Homelessness Incentive Program (HHIP) to Jamboree Housing to adapt the Budget Inn Motel, resulting in 89 units. At the event, I was joined by Supervisor and CalOptima Health Board Vice Chair Vicente Sarmiento, who also provided remarks.

H. At-Home Cologuard Tests Will be Sent to Members

CalOptima Health Community Network (CHCN) members who are due for colorectal cancer screening will soon receive an at-home Cologuard test. The easy-to-use screening test is covered by CalOptima Health at no cost to our members. Results are usually ready within two weeks, and the member's primary care provider will receive a copy of the results and consult with the member. Our Quality Initiatives team is also sending Member Health Reward Program mailings promoting colorectal cancer screenings to eligible Medi-Cal and OneCare members. The goal is to bring awareness to the importance of colorectal cancer screening and inform members about the reward they may be eligible for after completing their screening.

I. CalOptima Health Removes Prior Authorization for Select Screenings for OneCare Members

Because timely screenings are crucial for preventing serious health conditions for our members, we have removed prior authorizations for OneCare members for the following services:

- Colon cancer screening — Colon cancer is the second most common cause of cancer deaths in the U.S., and more than 150,000 people are diagnosed annually. With appropriate screening, colorectal polyps can be found and removed before they become cancerous.

- Breast cancer screening — Breast cancer is the most common type of cancer in women. One in every eight women in the U.S. will be diagnosed with breast cancer, and more than 300,000 people in the U.S. are diagnosed annually. Women who receive regular breast cancer screenings have a 26% lower breast cancer death rate than women who aren't regularly screened.
- Diabetic eye exam — Diabetic retinopathy is the leading cause of blindness in working-age adults, and, if left untreated, it can cause permanent vision loss. Early treatment can prevent or delay blindness from diabetic retinopathy in more than 90% of diabetics. The annual eye exam is the only way to monitor changes in the eyes of diabetic members.

J. Press Release Distributed on Behavioral Health Workforce Grant Funding

On November 13, CalOptima Health distributed a press release announcing $5.1 million in grant funding to increase the behavioral health workforce as part of our ongoing Provider Workforce Development Initiative. This funding builds on the initial $24.6 million CalOptima Health awarded in April 2024 as part of the five-year, $50 million Provider Workforce Development Initiative aimed at enhancing the health care workforce across Orange County. The initiative is focused on increasing access to care by supporting the recruitment, training and retention of qualified health professionals. With the distribution of the remaining $20.3 million still ahead, CalOptima Health will consider areas of greatest need to ensure equitable and accessible health care for our diverse membership.

CalOptima Health

Fast Facts
December 2024

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

Membership Data* (as of October 31, 2024)

Total CalOptima Health Membership

910,063

Program	Members
Medi-Cal	892,392
OneCare (HMO D-SNP)	17,173
Program of All-Inclusive Care for the Elderly (PACE)	498

*Based on unaudited financial report and includes prior period adjustment

Operating Budget (for four months ended October 31, 2024)

	YTD Actual	YTD Budget	Difference
Revenues	$1,623,301,815	$1,422,996,834	$200,304,981
Medical Expenses	$1,586,004,481	$1,424,725,597	($161,278,884)
Administrative Expenses	$79,207,551	$96,381,292	$17,173,741
Operating Margin	($41,910,218)	($98,110,055)	$56,199,837
Medical Loss Ratio (MLR)	97.7%	100.1 %	(2.4%)
Administrative Loss Ratio (ALR)	4.9%	6.8%	1.9%

Notes:
- Totals may not add due to rounding
- Adjusted MLR is 93.4%, excluding estimated provider rate increases funded by reserves

Reserve Summary (as of October 31, 2024)

	Amount (in millions)
Board Designated Reserves	$1,030.5*
Statutory Designated Reserves	$135.1
Capital Assets (Net of depreciation)	$103.6
Resources Committed by the Board	$481.4
Board Approved Provider Rate Increases	$456.0
Resources Unallocated/Unassigned	$268.6*
Total Net Assets	$2,475.2

Total of Board-designated reserves and unallocated resources can support approximately 122 days of CalOptima Health's current operations.

Total Annual Budgeted Revenue **$4 Billion**

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

CalOptima Health Fast Facts

December 2024

Personnel Summary (as of November 16, 2024, pay period)

	Filled	Open	Vacancy % Medical	Vacancy % Administrative	Vacancy % Combined
Staff	1,318.5	73.15	44.82%	55.18%	5.26%
Supervisor	82	0	0%	0%	0%
Manager	114	7	28.57%	71.43%	5.79%
Director	68.25	2.5	60%	40%	3.53%
Executive	20	2	0%	100%	9.09%
Total FTE Count	1,602.8	84.7	47.89%	52.11%	5.02%

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

Provider Network Data (as of November 20, 2024)

	Number of Providers
Primary Care Providers	1,318
Specialists	6,999
Pharmacies	525
Acute and Rehab Hospitals	40
Community Health Centers	70
Long-Term Care Facilities	207

Treatment Authorizations (as of September 30, 2024)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	35.25 hours
Prior Authorization – Urgent	72 hours	16.58 hours
Prior Authorization – Routine	5 days	2.11 days

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

Member Demographics (as of October 31, 2024)

Member Age	
0 to 5	8%
6 to 18	23%
19 to 44	35%
45 to 64	20%
65 +	14%

Language Preference	
English	54%
Spanish	31%
Vietnamese	10%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	37%
Expansion	38%
Optional Targeted Low-Income Children	8%
Seniors	11%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

CalOptima Health, A Public Agency

Back to Agenda

2024 Signed and Vetoed State Legislation

Executive Summary

On September 30, 2024, Governor Gavin Newsom finished signing or vetoing all legislation that had been passed by the California State Legislature in 2024 — the second and final year of its 2023–24 legislative session, which had adjourned on August 31.

This *Executive Summary* includes the final outcomes and brief summaries of policy (non-budget) bills that were signed (12) or vetoed (7) by the governor and have been identified for potential impacts to CalOptima Health. In addition, *Full Summaries and Potential Impacts* of the identified legislation are included on subsequent pages.

Bill Number	Bill Title/Summary
SIGNED INTO LAW	
SB 339	**Human Immunodeficiency Virus (HIV) Preexposure Prophylaxis (PrEP) and Postexposure Prophylaxis (PEP):** Increases Medi-Cal coverage of PrEP and PEP furnished by a pharmacist from a 60-day maximum course to a 90-day maximum course.
SB 819	**Medi-Cal Mobile Health Care Site Enrollment:** Exempts mobile health care sites from enrolling in Medi-Cal as a separate provider if a part of a government-operated clinic that is exempt from licensure by the California Department of Public Health (CDPH).
SB 1120	**Artificial Intelligence (AI) in Utilization Review:** Requires a health plan's algorithms, AI and other software tools for utilization management to comply with specified fairness and equity requirements and to be based on individual clinical history and circumstances.
SB 1180	**Emergency Medical Services:** Requires Medi-Cal to cover services provided by a community paramedicine program, triage to alternate destination program, or mobile integrated health program.
SB 1289	**Medi-Cal Call Center Data:** Requires county Medi-Cal centers to collect and submit monthly data metrics to the Department of Health Care Services (DHCS) starting January 1, 2026.
AB 1316	**Psychiatric Emergency Medical Conditions:** Requires Medi-Cal to cover emergency services and care necessary to treat a psychiatric emergency medical condition.
AB 1936	**Maternal Mental Health Screenings:** Requires health plans to provide maternal mental health screenings at least once during pregnancy, at least once during the first six weeks following birth, and additional necessary to improve treatment and referrals to other services.
AB 2105	**PANDAS and PANS:** Requires health plans to cover prophylaxis, diagnosis and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS).
AB 2129	**Immediate Postpartum Contraception:** Authorizes a provider to separately bill for devices, implants and/or professional services associated with immediate postpartum contraception if the birth takes place in a general acute care hospital or licensed birth center.
AB 2340	**Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Informational Materials:** Requires informational materials regarding EPSDT services available under the Medi-Cal program to be standardized and distributed to beneficiaries and their parents.

AB 2843	**Rape and Sexual Assault Care:** Requires health plans to cover emergency room medical care and follow-up treatment following a rape or sexual assault.
AB 3275	**Claim Reimbursement:** Requires health plans to reimburse, contest or deny a complete claim within 30 calendar days after receipt beginning January 1, 2026. Also requires plans to treat any complaint from a beneficiary about a claims payment to be treated as a grievance.
VETOED	
SB 1423	**Rural Hospital Technical Advisory Group:** Would have required DHCS to convene an advisory group to analyze the ability of small, rural and critical access hospital to remain financially viable under existing Medi-Cal reimbursement methodologies.
AB 1470	**Behavioral Health Documentation Standards:** Would have required DHCS to standardize data elements relating to documentation requirements including medically necessary criteria.
AB 1975	**Medically Supportive Food:** Would have added medically supportive food and nutrition intervention plans as covered Medi-Cal benefits.
AB 2250	**Social Determinants of Health (SDOH) Screenings:** Would have added SDOH screenings as a covered Medi-Cal benefit on or after January 1, 2027.
AB 2339	**Medi-Cal Asynchronous Telehealth:** Would have expanded telehealth to include asynchronous electronic transmission initiated by patients, including via mobile applications.
AB 2428	**Community-Based Adult Services (CBAS) Rates:** Would have required Medi-Cal managed care plans (MCPs) to reimburse contracted CBAS providers at an amount equal to or greater than the Medi-Cal fee-for-service (FFS) rate.
AB 2446	**Diapers:** Would have added diapers as a covered Medi-Cal benefit for children under 21 years of age diagnosed with certain conditions, including those over three years old with incontinence.

DHCS and/or other state agencies are expected to issue further guidance regarding the implementation of signed legislation. Staff will monitor developments and share any updates from DHCS that may impact CalOptima Health.

On December 2, 2024, the California State Legislature will convene the new 2025–26 legislative session with the swearing-in of newly elected and re-elected legislators resulting from the November 5 election. Legislators will then reconvene on January 6 to begin conducting business, including authoring new legislation ahead of the February 21 bill introduction deadline. The vetoed bills outlined above are more likely to be re-introduced due to their support from legislators, as evidenced by their successful passage by the Legislature this year.

[Continued]

Full Summaries and Potential Impacts

Bill Number Author	Bill Summary/Impact	Bill Status	Position/Notes
SIGNED INTO LAW			
SB 339 Wiener	**HIV PrEP and PEP:** Increases Medi-Cal coverage of PrEP and PEP furnished by a pharmacist from a 60-day maximum course to a 90-day maximum course, which could be further extended under certain conditions. ***Potential CalOptima Health Impact***: Expanded Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**02/06/2024** Signed into law	CalOptima Health: Watch CAHP: Oppose
SB 819 Eggman	**Medi-Cal Mobile Health Care Site Enrollment:** Exempts intermittent or mobile health care sites from enrolling in Medi-Cal as a separate provider if operated by a government-operated clinic that is exempt from licensure by CDPH. ***Potential CalOptima Health Impact:*** Expansion of intermittent and mobile health care sites; increased access to care for CalOptima Health members.	**9/22/2024** Signed into law	CalOptima Health: Watch
SB 1120 Becker	**AI in Utilization Review:** Requires a health plan's use of algorithms, AI, and other software tools for utilization management (UM) purposes to comply with specified fairness and equity requirements and to be based on individual clinical history and circumstances. ***Potential CalOptima Health Impact:*** Implementation of new UM procedures.	**09/28/2024** Signed into law	CalOptima Health: Watch
SB 1180 Ashby	**Emergency Medical Services:** Adds services provided by a community paramedicine program, triage to alternate destination program, or mobile integrated health program as covered Medi-Cal benefits, subject to an appropriation by the Legislature. ***Potential CalOptima Health Impact:*** Expanded covered benefits for CalOptima Health Medi-Cal members.	**09/28/2024** Signed into law	CalOptima Health: Watch
SB 1289 Roth	**Medi-Cal Call Center Data:** Beginning on January 1, 2026, requires county Medi-Cal call centers to collect and submit monthly data metrics to DHCS. Beginning on May 15, 2026, requires DHCS to prepare a publish online a quarterly report on submitted call center. ***Potential CalOptima Health Impact:*** Increased resources for CalOptima Health members; increased number of CalOptima Health members as a result of additional new enrollments and fewer disenrollments.	**09/27/2024** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary/Impact	Bill Status	Position/Notes
AB 1316 Irwin	**Psychiatric Emergency Medical Conditions:** Requires the Medi-Cal program to cover emergency services and care necessary to treat a psychiatric emergency medical condition, including post-stabilization care services, emergency room professional services, and facility charges for emergency room visits — regardless of whether the beneficiary was voluntarily or involuntarily admitted. ***Potential CalOptima Health Impact***: Increased scope of behavioral health services for CalOptima Health Medi-Cal members.	**09/27/2024** Signed into law	CalOptima Health: Watch
AB 1936 Cervantes	**Maternal Mental Health Screenings:** Requires a health plan's maternal mental health program to consist of at least one maternal mental health screening during pregnancy, at least one additional screening during the first six weeks of the postpartum period, and additional postpartum screenings, if determined medically necessary and clinically appropriate, to improve treatment and referrals to other maternal mental health services, including coverage for doulas. ***Potential CalOptima Health Impact***: Expanded Medi-Cal benefit for CalOptima Health Medi-Cal members.	**09/28/2024** Signed into law	CalOptima Health: Watch
AB 2105 Lowenthal	**PANDAS and PANS**: Beginning January 1, 2025, requires a health plan to provide coverage for prophylaxis, diagnosis and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS), prescribed or ordered by a provider as medically necessary. ***Potential CalOptima Health Impact:*** Continued covered benefit for pediatric CalOptima Health Medi-Cal members.	**09/28/2024** Signed into law	CalOptima Health: Watch CAHP: Oppose
AB 2129 Petrie-Norris	**Immediate Postpartum Contraception:** No later than January 1, 2025, authorizes a provider to separately bill for devices, implants or professional services, or any combination thereof, associated with immediate postpartum contraception if the birth takes place in a general acute care hospital or licensed birth center. ***Potential CalOptima Health Impact:*** Modified Claims procedures for a covered Medi-Cal benefit.	**09/29/2024** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary/Impact	Bill Status	Position/Notes
AB 2340 Bonta	**EPSDT Informational Materials:** Requires DHCS to standardize informational materials that effectively explain and clarify the scope and nature of EPSDT services that are available under the Medi-Cal program, including content designed for youth. Requires a Medi-Cal MCP to provide the informational materials to EPSDT-eligible beneficiaries and their parents within a certain period (as determined by DHCS) of initial enrollment into the MCP and annually thereafter. ***Potential CalOptima Health Impact:*** Standardization and increased number of mailings to certain CalOptima Health Medi-Cal members.	**09/25/2024** Signed into law	CalOptima Health: Watch
AB 2843 Petrie-Norris	**Rape and Sexual Assault Care:** Beginning July 1, 2025, requires a health plan to provide coverage without cost-sharing for emergency room medical care and follow-up treatment following a rape or sexual assault. Also prohibits a health plan from requiring members to provide a police report or press charges for rape or sexual assault in order to receive care. ***Potential CalOptima Health Impact:*** Expanded covered benefits for CalOptima Health Medi-Cal members.	**09/29/2024** Signed into law	CalOptima Health: Watch
AB 3275 Soria	**Claim Reimbursement:** Beginning January 1, 2026, requires health plans to reimburse, contest or deny a complete claim within 30 calendar days after receipt of the claim, or otherwise be subject to current 15% per annum interest requirements. If a plan does not automatically include any accrued interest in its payment, this bill increases the penalty fee from $10 to the greater of $15 or 10% of accrued interest. In addition, requires health plans to treat a complaint from an enrollee about the delay or denial of a claim payment to be treated as a grievance, regardless of whether the term grievance is used. ***Potential CalOptima Health Impact:*** Decreased claim review time for CalOptima Health staff; increased number of member grievances; increased interest and penalty payments to CalOptima Health contracted providers.	**09/27/2024** Signed into law	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose

Bill Number Author	Bill Summary/Impact	Bill Status	Position/Notes
VETOED			
SB 1423 Dahle	**Rural Hospital Technical Advisory Group:** Would have required DHCS to convene a Rural Hospital Technical Advisory Group — including representatives from Medi-Cal MCPs and their state associations — to analyze the ability of small, rural and critical access hospitals to remain financially viable under existing Medi-Cal reimbursement methodologies and to provide related recommendations by March 31, 2026. ***Potential CalOptima Health Impact***: CalOptima Health representation on DHCS committee; consideration of modified payments to CalOptima Health contracted critical access hospitals.	**09/22/2024** Vetoed due to new costs for duplicative efforts *(see full **veto message**)*	CalOptima Health: Watch
AB 1470 Quirk-Silva	**Behavioral Health Documentation Standards:** Would have required DHCS to standardize data elements relating to documentation requirements, including medically necessary criteria and develop standard forms containing information necessary to properly adjudicate claims. No later than July 1, 2025, regional personnel training on documentation would have needed to be completed along with the exclusive use of the standard forms. ***Potential CalOptima Health Impact***: New data requirements; additional training for CalOptima Health behavioral health staff on new documentation.	**09/14/2024** Vetoed due to duplicative efforts in place *(see full **veto message**)*	CalOptima Health: Watch
AB 1975 Bonta	**Medically Supportive Food:** No sooner than July 1, 2026, and subject to an appropriation by the Legislature, would have added medically supportive food and nutrition intervention plans as covered Medi-Cal benefits, when determined to be medically necessary to a patient's medical condition by a provider or plan. The benefit would have been based in part on the following Community Support offered through CalAIM: Medically Tailored Meals. ***Potential CalOptima Health Impact***: Formalization and expansion of certain Community Support services as covered benefits for eligible CalOptima Health Medi-Cal members.	**09/25/2024** Vetoed due to state budget constraints *(see full **veto message**)*	CalOptima Health: Watch LHPC: Support CAHP: Support

Bill Number Author	Bill Summary/Impact	Bill Status	Position/Notes
AB 2250 Weber	**SDOH Screenings:** Would have added SDOH screenings as a covered Medi-Cal benefit on or after January 1, 2027, contingent upon an appropriation by the Legislature. Would have also required health plans to provide primary care providers with adequate access to community health workers, social workers and peer support specialists. In addition, would have required Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to be reimbursed for these services at the Med-Cal FFS rate. ***Potential CalOptima Health Impact***: New covered benefits for CalOptima Health Medi-Cal members.	**09/22/2024** Vetoed due to duplicative efforts at the state and federal level and difficulty in operationalization *(see full **veto message**)*	CalOptima Health: Watch LHPC: Support
AB 2339 Aguiar-Curry	**Medi-Cal Asynchronous Telehealth:** Would have expanded telehealth capabilities to include asynchronous electronic transmission initiated directly by patients, including through mobile telephone applications. Would also have authorized a health care provider to establish a new patient relationship using asynchronous store and forward when the visit is related to sensitive services. ***Potential CalOptima Health Impact***: Expanded telehealth capabilities for CalOptima Health Medi-Cal members.	**09/20/2024** Vetoed due to lack of consumer protection in prescribing and treating reproductive and behavioral health disorders *(see full **veto message**)*	CalOptima Health: Watch
AB 2428 Calderon	**CBAS Rates:** Would have required Medi-Cal MCPs to reimburse contracted CBAS provider at an amount equal to or greater than the Medi-Cal FFS rate. ***Potential CalOptima Health Impact***: Increased payments to CalOptima Health contracted CBAS providers.	**09/14/2024** Vetoed due to existing payment increases and hesitancy to create precedent in law for one provider type *(see full **veto message**)*	CalOptima Health: Watch
AB 2446 Ortega	**Diapers:** Would have added 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 EPSDT standards ***Potential CalOptima Health Impact:*** New covered benefit for pediatric CalOptima Health Medi-Cal members.	**09/27/2024** Vetoed due to state budget constraints *(see full **veto message**)*	CalOptima Health: Watch

CAHP: California Association of Health Plans
LHPC: Local Health Plans of California

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

November 7, 2024

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on November 7, 2024, 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 Becerra called the meeting to order at 2:02 p.m., and Director Blair Contratto led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair; Supervisor Vicente Sarmiento, Vice Chair; Maura Byron; Supervisor Doug Chaffee (left room at 3:19 and returned at 3:21 p.m.); Blair Contratto; Norma García Guillén; Catherine Green, R.N.; Brian Helleland; Veronica Kelley (non-voting)

(All Board members in attendance participated in person)

Members Absent: Jose Mayorga, M.D.

Others Present: 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 that staff would like to reorder the agenda to hear Agenda Item 14 immediately before Agenda Item 18.

PRESENTATIONS/INTRODUCTIONS

1. Celebrating Employee Milestone Work Anniversaries

Steve Eckberg, Chief Human Resources Officer, recognized employees' milestone work anniversaries for calendar year 2024.

MANAGEMENT REPORTS

2. Chief Executive Officer (CEO) Report

Yunkyung Kim, Chief Operating Officer, presented the CEO Report on behalf of Michael Hunn. Ms. Kim started by expressing on behalf of the management team, gratitude and admiration to the CalOptima Health employees who celebrated their anniversaries this calendar year. She added that they have been real leaders at CalOptima Health for many years and helped to further the agency's success here in Orange County.

Ms. Kim highlighted several items from the CEO Report, which included the California State Auditor (CSA) Report, and noted that back in 2022-2023, the CSA conducted a comprehensive nine-month audit of CalOptima Health that spanned an eight-year period from January 1, 2014, through June 2022. Ms. Kim reviewed some of the areas that the audit covered which included CalOptima Health's hiring practices, salary scale, compliance program, reserve spending and surplus funds, as well as reporting

transparency. Ms. Kim shared that she is pleased to report to the Board and to the public that after submitting CalOptima Health's 60-day, six months, and one year status updates to the state auditor office, the audit is formally closed, indicating that CalOptima Health has fully implemented all the recommendations in the CSA's report.

Ms. Kim highlighted two quality items from the CEO Report. First on the Medi-Cal front, CalOptima Health met all the Department of Health Care Services (DHCS) required performance levels on the Managed Care Accountability Set (MCAS). She noted that DHCS measures CalOptima Health's performance based on the MCAS measures, and this year the agency met all 18 measures. Ms. Kim added that in previous years staff was working to close the gap on some MCAS measures where CalOptima Health did not meet the performance level required by DHCS.

The second quality item that Ms. Kim highlighted was on the OneCare Program. The OneCare program is regulated by the Centers for Medicare & Medicaid Services (CMS). Ms. Kim noted that CMS released its star ratings of health plans for 2025 and CalOptima Health dropped from a three-star plan to a two-and-a-half-star plan. Ms. Kim reviewed in detail the areas where CalOptima Health performance levels dropped and outlined some of the remediation efforts that the agency is undertaking. Ms. Kim added that CalOptima Health is also working with its health networks and providers as well as its members to increase its star rating by addressing deficiencies. She also added that CalOptima Health takes this very seriously and will provide ongoing updates to the Board and public.

Ms. Kim reviewed the Fast Facts, reporting that CalOptima Health currently serves a little over 913,000 individuals.

CalOptima Health's Board-designated reserves are a little over $1 billion; its capital assets are $103.9 million; its resources committed by the Board are $485.7 million; its Board-approved provider rate increases are $473.6 million; and its unallocated and unassigned resources are $242.5 million. Ms. Kim noted that CalOptima Health's total net assets are currently $2.4 billion.

Ms. Kim also added that the usual information in the Fast Facts, the personnel summary, provider network data, treatment authorization, and member demographics are in the materials. She noted that CalOptima Health is now providing additional details on the provider network trends, which include year-over-year comparisons. The additional information was requested by the CalOptima Health Board and will be included on a quarterly basis.

Ms. Kim also reported that on October 30, CalOptima Health hosted a listening session with DHCS Director Michelle Baass, as well as others from the DHCS leadership team, including the California State Medicaid Director Tyler Sadwith. DHCS joined CalOptima Health and nearly 40 partners from Orange County and community-based organizations. The purpose of the listening session was to share with DHCS CalOptima Health's and its partners experience on the ground with the implementation of CalAIM. The state wanted to hear from Orange County, how the past two years of implementing CalAIM's Enhanced Care Management (ECM) and Community Supports (CS) benefits at CalOptima Health has worked, as well as the collaboration between it and its county and community partners. The meeting was also an opportunity to talk about some of the things that are coming up in CalAIM, including behavioral health transformation, the justice involved program, and the transitional rent benefit that are scheduled to begin shortly. Ms. Kim noted that it was a good opportunity for Orange County to highlight how it has worked together, and also provided feedback on some of the challenges and suggestions on what works best for Orange County as the state implements additional CalAIM programs going forward.

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Ms. Kim also added that at the end of the meeting, DHCS had a chance to sit down with some of CalOptima Health's members, members of the Member Advisory Committee, and members of the Whole-Child Model Family Advisory Committee, who shared their experience and that of their families with regard to the implementation of CalAIM's various programs. Ms. Kim noted that in addition to the committee members, and community partners who attended the listening session with DHCS, CalOptima Health Chair Isabel Becerra and Director Veronica Kelley were also in attendance. Ms. Kim invited Chair Becerra and Director Kelley to share any comments they had from the listening session.

Chair Becerra noted that it was an honor to attend and provide feedback in person. She added that it was so nice to see genuine interest from the state on the feedback on CalAIM initiatives implemented here at CalOptima Health and Orange County.

Director Kelley noted that from a county perspective, and as an early advocate for ECM and CS services, and a requirement that providers work with county behavioral health, she was happy to report that the county may not be the best provider of ECM and CS services as previously thought. However, due to the strong collaboration between CalOptima Health, the county, and other community partners working together, Orange County can realize better health care for all beneficiaries. Director Kelley added that she was grateful to be included in the listening session and share the county's experience regarding CalAIM.

Ms. Kim thanked Chair Becerra and Director Kelley for their comments and thanked all the community partners for their participation and sharing their experience with the state.

Ms. Kim also reported that this Board meeting is taking place right after an election and while many of the results are still being tabulated and will be finalized in the next several weeks, she wanted to point out some of the changes that may directly impact CalOptima Health. One of the changes is related to Proposition 35, which is expected to be approved by a fairly wide margin. Proposition 35 will make permanent the existing managed care organization tax, which is a tax that health plans like CalOptima Health pay in order to draw down federal funds. Proposition 35, if approved, would have strict funding allocations for Medi-Cal rate increases for certain provider types. CalOptima Health will keep the Board and the public updated on this change and any other changes that affect its members and providers.

Ms. Kim noted that today, CalOptima Health was made aware that the Governor has issued a proclamation to convene a special session of the California State Legislature with the aim to safeguard California's values and fundamental rights in the face of an incoming change in the federal administration. The special session will focus on bolstering California's legal resources to protect civil rights, reproductive freedom, climate action, and immigrant families. CalOptima Health will update the Board and public on the results of the special session.

Lastly, Ms. Kim updated the Board on recent results of one of CalOptima Health's community partners and their recent distribution of Naloxone. The community partners knocked on 738 doors, and 396 of those doors opened. That is an astonishing 54% rate of people opening their door to someone knocking to provide education on Naloxone, as well as provide Naloxone. Three-hundred seventy-six households received that education, which include information that CalOptima Health created, largely in conjunction with the Orange County Health Care Agency. And 275 doses of Naloxone were received by these families. The message that this partner used was "is your medicine cabinet complete," recognizing that sometimes this is really about the unexpected places where fentanyl might show up and the impact to families. Ms. Kim highlighted that this community partner is also a participant in CalOptima Health Nonprofit Healthcare Academy, which CalOptima Health implemented last year to bolster the capabilities

and capacity of its local partners. With this partner's permission, Ms. Kim noted that she would love to share with the Board some of the real stories and experiences that CalOptima Health members shared with the promotoras. Ms. Kim noted that she would send the stories to the Board after she receives permission.

3. Fiscal Year 2025-2027 Strategic Plan Discussion Draft

Donna Laverdiere, Executive Director, Strategic Development, presented an overview of the Fiscal Year (FY) 2025-2027 Strategic Plan Discussion Draft, noting that the purpose of today's presentation is to take a moment to understand the plan and bring it forward for public viewing. Ms. Laverdiere noted that in Spring 2024, staff gathered best practices from other public Medi-Cal plans, reviewed prior Strategic Priorities and results, received input from CalOptima Health leadership and staff, and reviewed upcoming regulatory requirements and in-flight strategic initiatives. In Summer 2024, staff reviewed a draft Strategic Plan with stakeholders to obtain their feedback, which included participation from the Member and Provider Advisory Committees, Health Network Forum, Whole-Child Model Family Advisory Committee, and other stakeholders. Ms. Laverdiere reviewed the five Strategic Plan components, which include a Mission, a Vision, Values, Strategic Priorities, and Organizational Goals. She noted that staff is revisiting CalOptima Health's Mission and Vision. She noted that staff is proposing to keep the existing Mission but reviewed the three options for updating CalOptima Health's Vision. CalOptima Health's Values will lead with CalOptima Health C-A-R-E-S to best serve the people of Orange County; CalOptima Health will lead with Collaboration, Accountability, Respect, Excellence, and Stewardship. Ms. Laverdiere reviewed the four Strategic Priority areas that CalOptima Health will focus on, which are Equity & Population Health, Quality & Value, Community Partnership & Investments, and Operational Excellence. Ms. Laverdiere briefly reviewed the components under each of the four Strategic Priority areas and asked the Board for feedback.

Ms. Kim and Ms. Laverdiere responded to Board members' comments and questions.

ADVISORY COMMITTEE UPDATES

4. Joint Meeting of the Member Advisory Committee (MAC) and the Provider Advisory Committee (PAC)

Christine Tolbert, MAC Chair, provided updates on the recent activities at the MAC and PAC joint meeting. She reported that the committees welcomed a new MAC member for the standing Social Services Agency seat and are currently recruiting for two OneCare seats.

PUBLIC COMMENTS

1. Angkeroth Lead, CalOptima Health Member: Oral report regarding Agenda Item 13, using a translator.
2. Lily Un, CalOptima Health Member: Oral report regarding Agenda Item 13, using a translator.
3. Daline Tekim, CalOptima Health Member: Oral report regarding Agenda Item 13, using a translator.
4. Armina Sen-Matthews, The Cambodian Family Community Center: Oral report regarding Agenda Item 13.
5. Michael Arnot: Oral report regarding Agenda Item 13.

CONSENT CALENDAR

5. Minutes

a. Approve Minutes of the October 3, 2024, Regular Meeting of the CalOptima Health Board of Directors
b. Receive and File Minutes of the June 12, 2024, Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

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6. Approve Modifications to CalOptima Policy AA.1207b and AA.1207c: Performance-based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology and Performance-based Community Health Center Auto-Assignment Allocation Methodology

7. Approve CalOptima Health Measurement Year 2025 Medi-Cal and OneCare Pay-for-Value Programs

This item was pulled from the Consent Calendar for discussion and separate vote by Vice Chair Sarmiento.

8. Approve Recommendations for the Chair and Vice Chair Appointments to the Whole-Child Model Family Advisory Committee

9. Ratify Amendment to CalOptima Health's Primary Agreement with the California Department of Health Care Services

10. Adopt Resolution No. 24-1107-02 Approving and Adopting Updated CalOptima Health Human Resources Policy

11. Authorize Amendments to Extend the Term of Contracts with Translation and Interpreter Services Vendors

12. Receive and File:

a. September 2024 Financial Summary
b. Compliance Report
c. Federal and State Legislative Advocates Reports
d. CalOptima Health Community Outreach and Program Summary

Action: ***On motion of Director Green, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 5 through 12, minus Agenda Item 7, as presented. (Motion carried; 8-0-0; Director Mayorga absent)***

7. Approve CalOptima Health Measurement Year 2025 Medi-Cal and OneCare Pay-for-Value Programs

Vice Chair Sarmiento asked staff to provide some background on this item.

Ms. Kim reviewed the item noting that staff are aligning CalOptima Health's Pay-for-Value Performance Programs for both OneCare and Medi-Cal to help remediate CalOptima Health low performance in certain areas. The idea is that CalOptima Health and its provider partners win together, share in losses together, and are in this together.

Vice Chair Sarmiento noted that he is fully in support of this item.

Action: ***On motion of Vice Chair Sarmiento, seconded and carried, the Board of Directors: 1.) Approved Measurement Year 2025 Medi-Cal Pay for Value***

Performance Program for the period effective January 1, 2025, through December 31, 2025; 2.) Approved Measurement Year 2025 OneCare Pay for Value Performance Program for the period effective January 1, 2025, through December 31, 2025; and 3.) Approved the use of unearned Measurement Year 2025 Pay for Value Performance Program funds for quality initiatives and grants. (Motion carried; 8-0-0; Director Mayorga absent)

Chair Becerra noted for the record that she would not be participating in Agenda Items 13, 15, 16, and 17 due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and would leave the room during the discussion and vote. Chair Becerra passed the gavel to Vice Chair Sarmiento.

REPORTS/DISCUSSION ITEMS

13. Approve Award Recommendations for Workforce Development Initiative Round Two Grants

Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and left the room during the discussion and vote. Director Contratto did not participate in this item due to her role as Chief Strategy Officer at Mind OC/Be Well OC and left the room during the discussion and vote.

Ms. Laverdiere introduced this item.

There were five public comments on this item as noted above under Public Comments.

Board members had many questions for staff after hearing staff's introduction of the item and the comments from members of the public. The comments included asking staff to see if they could tailor additional Workforce Development Initiatives grants to address smaller organizations that may not score as high as other organizations, but that nonetheless provide needed and underfunded services to CalOptima Health's members.

Ms. Kim and Ms. Laverdiere responded to Board members' comments and questions.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer, or designee, to enter into grant agreements with the recommended six grantees; a.) Approved the selection of six recommended grantees with corresponding grant award allocations totaling $5,140,742 for provider workforce training and development innovation to increase the pipeline of health care professionals in Orange County; b.) Authorized an increase to the Provider Workforce Development Initiative allocation from $5 million to $5,140,742 for provider workforce training and development innovation, coming from the $50 million restricted Provider Workforce Development Fund; 2.) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose; and 3.) Directed the Chief Executive Officer to modify the five-year Provider Workforce Development Fund to extend the timeline for an additional two years, through 2030. (Motion carried; 6-0-0; Chair Becerra and Director Contratto recused; Director Mayorga absent)***

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15. Authorize the Chief Executive Officer to Use Reserve Funds to Make Payments to Primary Care Practices Participating in the Equity and Practice Transformation Payment Program Prior to Receipt of Funds Included in the State of California Fiscal Year 2024-25 Budget

Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and left the room during the discussion and vote.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer, or designee, to make directed payments to Medi-Cal primary care practices participating in the Equity and Practice Transformation Payment Program; and 2.) Authorized expenditures of $228,080.80 from existing reserves to fund the initial directed payments prior to the receipt of funds included in the State of California Fiscal Year 2024-25 budget. (Motion carried; 7-0-0; Chair Becerra recused; Director Mayorga absent)***

16. Authorize the Chief Executive Officer to Execute Contract Amendments with Collective Medical Technologies, Inc., a PointClickCare company, and Safety Net Connect, Inc. to Improve Information Exchange for Members and Providers Across Care Settings

Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and left the room during the discussion and vote.

A motion was made to continue this item to a future meeting.

Action: ***On motion of Director García Guillén, seconded and carried, the Board of Directors made a motion to continue this item to a future meeting. (Motion carried; 7-0-0; Chair Becerra recused; Director Mayorga absent)***

17. Approve Actions Related to the CalAIM Incentive Payment Program for Justice-Involved Services Learning Collaborative Selected Recipients

Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and left the room during the discussion and vote. Director Contratto did not participate in this item due to her role as Chief Strategy Officer at Mind OC/Be Well OC and left the room during the discussion and vote.

Supervisor Chaffee noted what an important program this is, which aligns with the county's justice reform, Project Rebound.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Approved CalOptima Health staff's recommendations to administer grant agreements and award payments totaling $1,000,000 from the CalAIM Incentive Payment Program, Program Year 1, to the selected grant recipients (listed in Attachment 1) for the Justice-Involved Services Learning Collaborative program. (Motion carried; 6-0-0; Chair Becerra and Director Contratto recused; Director Mayorga absent)***

Vice Chair Sarmiento passed the gavel back to Chair Becerra.

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14. Adopt Resolution No. 24-1107-01 Approving the Revised 2025 CalOptima Health Compliance Plan, 2025 CalOptima Health Code of Conduct, 2025 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan, 2025 CalOptima Health HIPAA Privacy and Security Program, and Revised CalOptima Health Office of Compliance Policies and Procedures.

Vice Chair Sarmiento commented that he did not see anything having to do with familial relationships in the Code of Conduct, Section 5. Conflicts of Interests,.

John Tanner, Chief Compliance Officer, responded that he would go back and check, but noted that each employee and Board member files a Conflict of Interest Form 700 and would note those types of relationships on that form. Mr. Tanner also said he could add language on familial relationships in Section 5 of the Code of Conduct.

Vice Chair Sarmiento referenced L.A. Care Health Plan's Code of Conduct as an example and noted that he would support this motion as amended with the familial relationships added to Section 5.

The Board approved the motion below with a request to add the language on familial relationships to Section 5 of the Code of Conduct. The amended language will be included in the November 7, 2024, Board Meeting Materials archive.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Adopted Resolution No. 24-1107-01 approving: a.) The revised 2025 CalOptima Health Compliance Plan; 2025 CalOptima Health Code of Conduct; 2025 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan; and the 2025 CalOptima Health HIPAA Privacy and Security Program; and b.) Revised CalOptima Health Office of Compliance policies and procedures. (Motion carried; 8-0-0; Director Mayorga absent)***

18. Approve Modifications to the CalOptima Health Mental Health (Non-Applied Behavior Analysis) Provider Pay-for-Value Program

Action: ***On motion of Vice Chair Sarmiento, seconded and carried, the Board of Directors approved the modifications to the Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program measures. (Motion carried; 8-0-0; Director Mayorga absent)***

CLOSED SESSION

The Board adjourned to Closed Session at 4:01 p.m. Pursuant to Government Code section 54956.9(d)(2): 1 Case, CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION and Pursuant to Government Code section 54956.9(d)(4): 1 Case, CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION.

The Board returned to Open Session at 5:06 p.m. and the Clerk re-established a quorum.

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ROLL CALL

Members Present: Isabel Becerra, Chair; Supervisor Vicente Sarmiento, Vice Chair; Maura Byron; Blair Contratto (returned back from Closed Session at 4:22 p.m.); Norma García Guillén; Catherine Green, R.N.; Brian Helleland; Veronica Kelley (non-voting) (All Board members in attendance participated in person)

Members Absent: Supervisor Doug Chaffee; Jose Mayorga, M.D.

CLOSED SESSION

Chair Becerra noted that the Board met in Closed Session and there were no reportable actions taken.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Chair Becerra reminded the Board members to complete their compliance training if they have not already done so.

Director Byron thanked Director Kelley, Supervisor Sarmiento, and Michael Hunn for participating in the Second Annual Orange County Summit hosted by the We Can Coalition. The summit focused on improving care for families affected by perinatal substance use. Director Byron added that she appreciated their support and attendance.

Director Contratto commented on Agenda Item 18, noting there was not a lot of discussion, but wanted to note for the record that as she shared with staff previously she was disappointed that CalOptima Health did not stay with the original 10 criteria for value-based payments in behavioral health, because she thinks it is so desperately needed, and instead gone to seven far less specific payment methodologies. Director Contratto added the seven methodologies are quite generic and hopes that CalOptima Health can move towards something more rigorous in terms of incentives for those providers, much like it does for the rest of its network.

Ms. Kim responded that CalOptima Health will work with behavioral health professionals as they grow their practices, since these practices do not have the infrastructure that many other medical professionals have, and will hold them to a high standard of care to earn incentives.

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: December 5, 2024

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MINUTES

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

CALOPTIMA HEALTH
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

September 19, 2024

A Regular Meeting of the CalOptima Health Board of Directors' (Board) Finance and Audit Committee (FAC) was held on September 19, 2024, 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; Blair Contratto (All members participated in person)

Members Absent: Brian Hellelund

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operation Officer; Nancy Huang, Chief Financial Officer; Troy Szabo, Outside General Counsel, Kennaday Leavitt; Sharon Dwiers, Clerk of the Board

The Clerk noted that no changes were made to the agenda.

MANAGEMENT REPORTS

1. Chief Financial Officer Report

Nancy Huang, Chief Financial Officer, provided four verbal updates for the meeting. The first update included provider rate increases for the fiscal year; the second update was related to year-end budget reconciliations; and the third and fourth updates were related to two ratification actions on the agenda for the Investment Advisory Committee (IAC) membership. Ms. Huang noted that the two ratification actions, Agenda Items 5 and 6, were due to a clerical error and staff has since strengthened processes to ensure timely reporting of IAC actions.

For the first update, Ms. Huang began with the provider rate increase that was approved by the Board in May 2024. CalOptima Health allocated $526.2 million from reserves to support a provider rate increase over 30 months, starting in July 2024. The operating budget for Fiscal Year (FY) 2024-2025, which was approved in June 2024, includes $210.5 million for this purpose. Additionally, $173 million was allocated for the Department of Health Care Services phased targeted rate increase (TRI) for eligible providers. The contract update and system implementation for the TRI have been completed, and payments to providers will be at the updated rates starting July 1, 2024. Finally, fee-for-service and capitated providers will also

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receive payments at the updated rates. Retroactive payments were made to providers for the period of January 1, 2024, to June 30, 2024.

Ms. Huang provided an update regarding modifications to reserve policy, GA.3001: Statutory and Board Designated Reserve Funds, which was approved by the Board in May 2024. There were two major changes to the policy. The first was to increase the Board-designated reserve range from 1.4 months of consolidated capitation revenues to no less than 2.5 and no more than 3.0 months of consolidated revenues. The second change was to create a separate reserve fund to meet the tangible net equity (TNE) required by the California Department of Managed Health Care. The implementation of the policy changes ensures compliance with the new TNE requirements. In June, staff worked with investment advisors to implement the policy changes. The Board-designated reserves are currently at 2.82 months of consolidated capitation revenues.

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. Mr. Steele did note that CalOptima Health experienced one notable non-reportable incident related to an unsuccessful device compromise in the second quarter of 2024 and one notable non-reportable cybersecurity outage in the third quarter of 2024 related to a CrowdStrike global outage. Mr. Steele also reported that CalOptima Health experienced two notable third party cybersecurity incidents, one in the second quarter of 2024 related to Optum/Calibrated Health and one in the third quarter of 2024, related to the Public Agency Retirement Services (PARS) business email compromise.

Mr. Steele provided details regarding the CalOptima Health compromised device, noting that the device was being tested and thanks to the multi-layered security that CalOptima Health has in place, the attack was stopped before any damage could be done. In addition, the security team brought in an external forensics team to ensure that there were no further security threats due to this device compromise.

Mr. Steele provided additional details regarding the CrowdStrike global outage that occurred on July 18, 2024. He explained that the outage was caused by a faulty update at CrowdStrike, which impacted flights, services at hospitals, and many other organizations. CalOptima Health experienced server and user disruptions for approximately nine hours. CalOptima Health's security team is actively evaluating the effectiveness and risk of CalOptima Health's security tools, including CrowdStrike. These evaluations will determine if staying with CrowdStrike is the best option or if additional tools should be considered for improved security.

Mr. Steele reported on a final incident that occurred, which was a third-party security breach involving PARS. Mr. Steele explained that a PARS employee's email account containing CalOptima Health employee data was compromised. The attacker used a phishing email disguised as a Dropbox link, which led the PARS employee to a simulated Microsoft login page. The PARS employee provided their multi-factor authentication code allowing the attacker to gain access. The incident occurred on March 11, 2024, and March 14, 2024, and impacted 1,565 CalOptima Health employees. CalOptima Health was notified on July 11, 2024, and its employees were notified both internally and from PARS. Currently there is no indication that the data has been misused.

Mr. Steele also updated the committee on the various security projects that have been completed and provided details of the current projects in flight and timelines for those projects.

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Mr. Hunn and Mr. Steele responded to committee members' comments and questions.

INVESTMENT ADVISORY COMMITTEE UPDATE

3. Treasurer's Report

Ms. Huang presented the Treasurer's Report for the period of April 1, 2024, through June 30, 2024. The portfolio totaled approximately $3.4 billion. Of the total portfolio amount, $2.2 billion was in CalOptima Health's operating account and approximately $1 billion was included in CalOptima Health's Board-designated reserves. Additionally, as previously reported, CalOptima Health now has a new reserve account with a total of $130.2 million set aside for TNE requirements. Meketa Investment Group Inc. (Meketa), CalOptima Health's investment advisor, completed an independent review of the monthly investment reports. Meketa reported that all investments were compliant with Government Code section 53600 *et seq*. and with CalOptima Health's Board-approved Annual Investment Policy during that period.

Director Contratto directed staff to add the word months to future documents with references to the reserve levels for the Board-designated reserve fund for clarity. The reserve fund is currently 2.82 months of consolidated capitation revenues, and the statutory-designated reserve fund, which is currently 1.03 months of consolidated capitation revenues meeting the required TNE levels.

Ms. Huang responded to committee members' questions.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

4. Approve the Minutes of the May 23, 2024, Special Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee and Receive and File Minutes of the April 22, 2024, Regular Meeting of the CalOptima Health Board of Directors' Investment Advisory Committee

5. Recommend Ratification of Appointment to the CalOptima Health Board of Directors' Investment Advisory Committee

6. Recommend Ratification of Reappointment and Committee Chair Appointment to the CalOptima Health Board of Directors' Investment Advisory Committee.

Action: ***On motion of Director Contratto, seconded and carried, the committee approved the Consent Calendar as presented. (Motion carried 2-0-0; Director Helleland absent)***

REPORTS/DISCUSSION ITEMS

7. Recommend that the Board of Directors Accept, Receive, and File the Fiscal Year (FY) 2023-24 CalOptima Health Audited Financial Statements

Ms. Huang introduced Moss Adams, LLP (Moss Adams), CalOptima Health's independent financial auditor, to provide further details on the audit results. Ms. Huang noted that she was happy to inform the FAC that there were no significant issues noted during the audit.

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Aparna Venkateswaran, Engagement Reviewer at Moss Adams, presented the draft audit of the consolidated financial statements for the FY ending June 30, 2024.

Ms. Venkateswaran presented an overview of the areas of audit emphasis, including capitation revenue and receivables, cash and investments, medical claims liability, and required communications. Ms. Venkateswaran reported that Moss Adams will be issuing an unmodified opinion indicating that the FY 2023-24 financial statements fairly state the financial condition of CalOptima Health in all material respects. Ms. Venkateswaran introduced Ashley Merda, Audit Senior Manager, who provided additional details on the audit.

Action: ***On motion of Director Contratto, seconded and carried, the committee recommended that the CalOptima Health Board of Directors accept, receive, and file the fiscal year 2023-24 CalOptima Health consolidated audited financial statements as submitted by independent auditors Moss Adams, LLP. (Motion carried 2-0-0; Director Helleland absent)***

8. Recommend Reappointments to the CalOptima Health Board of Directors' Investment Advisory Committee

Action: ***On motion of Director Contratto, seconded and carried, the committee recommended that the CalOptima Health Board of Directors reappoint the following individuals to the Board of Directors' Investment Advisory Committee for two (2)-year terms beginning October 6, 2024: 1.) Colleen Clark; 2.) David Hutchison, and 3.) James Meehan. (Motion carried 2-0-0; Director Helleland absent)***

9. Recommend Reappointment and Committee Chair Reappointment to the CalOptima Health Board of Directors' Investment Advisory Committee

Action: ***On motion of Director Contratto, seconded and carried, the committee recommended that the CalOptima Health Board of Directors reappoint Rodney Johnson: 1.) To the Investment Advisory Committee for a two (2)-year term, effective October 6, 2024; and 2.) To serve as Chair of the Investment Advisory Committee for a two (2)-year term, beginning October 6, 2024, and continuing until October 5, 2026, or until a successor is appointed. (Motion carried 2-0-0; Director Helleland absent)***

INFORMATION ITEMS

The following items were accepted as presented.

10. July 2024 Financial Summary

11. Quarterly Operating and Capital Budget Update

12. CalAIM Program Summary

13. Quarterly Reports to the Finance and Audit Committee

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a. Net Asset Analysis
b. Enrollment Trend Report
c. Shared Risk Pool Performance Update
d. Health Network Financial Compliance Review Update

COMMITTEE MEMBER COMMENTS
There were no committee member comments.

ADJOURNMENT
Hearing no further business, Chair Becerra adjourned the meeting at 3:56 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: November 21, 2024

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

3. Ratify the Acceptance, Receipt and Refiling of the Revised Fiscal Year 2023-24 CalOptima Health Audited Financial Statements

Contact

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

Recommended Action

Ratify the acceptance, receipt, and refiling of the revised fiscal year 2023-24 CalOptima Health consolidated audited financial statements as resubmitted by independent auditor, Moss Adams, LLP.

Background/Discussion

At the October 3, 2024, meeting, the CalOptima Health Board of Directors (Board) accepted, received, and filed the Fiscal Year (FY) 2023-24 CalOptima Health audited financial statements as submitted by Moss Adams, LLP (Moss Adams).

Following further review, Moss Adams identified one formula error in the FY 2023 (prior year) column in their audited financial statement package. The error incorrectly presented CalOptima Health's "Net investment in capital assets" and "Unrestricted" net position on pages 4, 6, and 24 of the audited financial statements. The following is the revised Statement of Net Position from page 24 of the audited financial statements:

	FY 2023 Original	FY 2023 Revised	Changes
NET POSITION			
Net investment in capital assets	115,592,667	**67,421,922**	(48,170,745)
Restricted by Legislative Authority	107,969,096	**107,969,096**	0
Unrestricted	1,446,444,514	**1,494,615,259**	48,170,745
Total net position	1,670,006,277	**1,670,006,277**	0

Under Governmental Accounting Standards Board Statement No. 96, the net value of Right-To-Use Subscription-Based Information Technology Arrangements must be included in net investments in capital assets.

Moss Adams corrected this error and provided staff with revised FY 2023-24 audited financial statements on October 28, 2024. Due to a Department of Managed Health Care filing deadline of October 31, 2024, staff uploaded the revised audited financial statements on October 29, 2024. On November 21, 2024, the Finance and Audit Committee approved staff's request to recommend that the Board ratify the acceptance, receipt, and refiling of the revised FY 2023-24 audited financial statements. Staff now submits the Finance and Audit Committee's recommendation to the Board for approval.

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Fiscal Impact
There is no net fiscal impact related to this recommended action.

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

Attachments
1. Revised FY 2023-24 CalOptima Health Audited Financial Statements (Redline and Clean versions)

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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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, 2024 and 2023

MOSSADAMS

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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, 2024, 2023, and 2022. 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, 2024, 2023, and 2022:

Key Operating Indicators	2024	2023	2022
Members (at end of fiscal period)			
Medi-Cal program	901,303	970,590	897,134
OneCare	17,253	17,687	2,668
OneCare Connect	-	-	14,415
PACE	496	439	429
Average member months			
Medi-Cal program	932,770	940,893	859,290
OneCare	17,488	17,443	2,342
OneCare Connect	-	14,360	14,682
PACE	457	434	417
Operating revenues (in millions)	$ 5,372	$ 4,239	$ 4,227
Operating expenses (in millions)			
Medical expenses	4,510	3,862	3,946
Administrative expenses	230	192	150
Operating income (in millions)	$ 633	$ 184	$ 131
Operating revenues PMPM (per member per month)	$ 471	$ 369	$ 402
Operating expenses PMPM			
Medical expenses PMPM	395	336	375
Administrative expenses PMPM	20	17	14
Operating income PMPM	$ 56	$ 16	$ 13
Medical loss ratio	84%	91%	93%
Administrative expenses ratio	4.3%	4.5%	3.6%
Premium tax revenue and expenses not included above			
Operating revenues (in millions)	$ 658	$ 90	$ 168
Administrative expenses (in millions)	$ 658	$ 92	$ 166

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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, 2024, 2023, and 2022, and the results of its operations for the fiscal years ended June 30, 2024, 2023, and 2022. 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), and Multipurpose Senior Services Program (MSSP).

- 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 addresses CalOptima Health's overall program activities. CalOptima Health's Medi-Cal program accounted for 91.5 percent, 89.8 percent, and 90.0 percent of its annual revenues during fiscal years 2024, 2023, and 2022, respectively. CalOptima Health's OneCare program accounted for 7.6 percent, 5.1 percent, and 0.9 percent of its annual revenues during fiscal years 2024, 2023, and 2022, respectively. CalOptima Health's OneCare Connect program accounted for 0.0 percent, 4.1 percent, and 8.1 percent of its annual revenues during fiscal years 2024, 2023, and 2022, respectively. All other programs in aggregate accounted for 0.9 percent, 1.1 percent, and 1.0 percent of CalOptima Health's annual revenues during fiscal years 2024, 2023, and 2022, respectively.

During Fiscal Year 2024, new laws and State contract changes impacted CalOptima Health's membership and financial statements. Beginning January 1, 2024, a new law in California provides full-scope Medi-Cal eligibility to adults ages 26 through 49, regardless of immigration status. The enrollment increase from Adult Expansion program was offset by the transition of Kaiser members 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.

2024 and 2023 Financial Highlights

As of June 30, 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.

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 1a: Condensed Statements of Net Position as of June 30,
(Dollars in Thousands)

Financial Position	2024	2023	Change from 2023 Amount	Change from 2023 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	100.0%
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	$ 4,182,274	$ 3,624,324	$ 557,950	15.4%
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)	100.0%
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~~ 67,422	~~12,696~~ 11,408	~~19.2%~~ 16.9%
Restricted by legislative authority	127,853	107,969	19,884	18.4%
Unrestricted	2,238,399	~~1,495,903~~ 1,494,615	~~742,496~~ 743,784	~~49.6%~~ 49.8%
Total net position	2,445,082	1,670,006	775,076	46.4%
Total liabilities, deferred inflows of resources, and net position	$ 4,182,274	$ 3,624,324	$ 557,950	15.4%

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 June 30, 2024, the Enhanced Care Management (ECM) risk corridor for the period of January 1, 2022 through June 30, 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.

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.

Statutory and 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 Tangible Net Equity (TNE) Requirement. In addition to the existing Board-designated reserve, the Board designated $100.0 million in total funding for homeless health initiatives (HHI) on April 4, 2019. On September 1, 2022, the Board approved a reallocation of the remaining $40.1 million from HHI to the state Housing and Homelessness Incentive Program (HHIP) initiatives. As of June 30, 2024, the total Board designated funding has been allocated.

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 1.0 to 1.10 times the requirement and CalOptima Health's 2024 reserves level stands at 1.03 times the TNE. CalOptima Health's total reserve level as of June 30, 2023, was at 1.78 times the monthly average consolidated capitation revenue.

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).

2023 and 2022 Financial Highlights

As of June 30, 2023 and 2022, total assets and deferred outflows of resources were approximately $3,624.3 million and $3,025.6 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately $1,670.0 million and $1,419.5 million, respectively.

Net position increased by approximately $250.5 million, or 17.6 percent, during fiscal year 2023 and increased by approximately $110.7 million, or 8.5 percent, during fiscal year 2022.

Table 1b: Condensed Statements of Net Position as of June 30,
(Dollars in Thousands)

Financial Position	2023	2022	Change from 2022 Amount	Change from 2022 Percentage
ASSETS				
Current assets	$ 2,937,296	$ 2,337,407	$ 599,889	25.7%
Board-designated assets and restricted cash	576,852	611,428	(34,576)	-5.7%
Capital assets, net	66,189	66,864	(675)	-1.0%
Intangible right-to-use subscription asset	18,018	18,018	-	0.0%
Total assets	3,598,355	2,525,826	1,072,529	42.5%
DEFERRED OUTFLOWS OF RESOURCES	25,969	9,626	16,343	169.8%
Total assets and deferred outflows of resources	$ 3,624,324	$ 3,025,586	$ 598,738	19.8%
LIABILITIES				
Current liabilities	$ 1,871,529	$ 1,551,389	$ 320,140	20.6%
Other liabilities	59,440	22,756	36,684	161.2%
Subscription liability, net of current portion	12,173	141	12,032	0.0%
Total liabilities	1,943,142	1,574,286	368,856	23.4%
DEFERRED INFLOWS OF RESOURCES	11,176	31,790	(20,614)	-64.8%
NET POSITION				
Net investment in capital assets	~~66,134~~ 67,422	66,772	~~(638)~~ 650	~~-1.0%~~ 1.0%
Restricted by legislative authority	107,969	107,346	623	0.6%
Unrestricted	~~1,495,903~~ 1,494,615	1,245,392	~~250,511~~ 249,223	~~20.1%~~ 20.0%
Total net position	1,670,006	1,419,510	250,496	17.6%
Total liabilities, deferred inflows of resources, and net position	$ 3,624,324	$ 3,025,586	$ 598,738	19.8%

Current assets increased $599.9 million from $2,337.4 million in 2022 to $2,937.3 million in 2023, primarily in cash and investments. Cash and investments had a net increase of $575.8 million primarily from increased enrollment and premium capitation rates. Current liabilities increased $320.1 million from $1,551.4 million in 2022 to $1,871.5 million in 2023 driven primarily by payables due to the State for the COVID-19 risk corridor for the period of July 1, 2019 through April 30, 2023, the Proposition 56 risk corridors for the period of January 1, 2021 through June 30, 2023, and the ECM risk corridor for the period of January 1, 2022 through June 30, 2023. In May 2023, the State finalized the bridge period (July 1, 2019 through December 31, 2020) Proposition 56 risk corridor and a payment was remitted to the State in June 2023 in the amount of $74.5 million.

Board-designated assets and restricted cash decreased by $34.6 million and increased by $3.6 million in fiscal years 2023 and 2022, respectively, primarily driven by changes to the portfolio's valuation. In addition to the existing Board-designated reserve, the Board designated $100.0 million in total funding for HHI on April 4, 2019. On September 1, 2022, the Board approved a reallocation of the remaining $40.1 million from HHI to the state HHIP initiatives. As of June 30, 2023, the balance of the HHI reserve was $21.0 million.

The Board's policy is to augment the rest of the Board-designated assets to provide a desired level of funds between 1.4 months and 2.0 months in consolidated capitation revenue to meet future contingencies. CalOptima Health's reserve level of Tier One and Tier Two investment portfolios as of June 30, 2023 and 2022, is at 1.78 and 1.75 times the monthly average consolidated capitation revenue, respectively.

CalOptima Health is also required to maintain a $300,000 restricted deposit as a part of the Act.

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 2a: 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	Change from 2023 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	4,509,912	3,862,196	647,716	16.8%
ADMINISTRATIVE EXPENSES	229,511	192,339	37,172	19.3%
Total operating expenses	4,739,423	4,054,535	684,888	16.9%
OPERATING INCOME	633,541	185,298	448,243	241.9%
NONOPERATING REVENUES AND EXPENSES	141,535	65,198	76,337	117.1%
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 is attributable to increased premium capitation rates, newly eligible UIS members, and $93.0 million in revenue from various State programs such as HHIP, Student Behavioral Health Incentive Program (SBHIP), and California Advancing and Innovating Medi-Cal (CalAIM) Incentive Payment Program (IPP). The increase in operating revenue is 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 net increase in payables to the State of $47.3 million for the Proposition 56, UIS, and ECM risk corridors.

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 79.0 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 are 187,207 or 28.5 percent and 232,786 or 33.7 percent 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 long-term care (LTC) services, increased by 15.4 percent from fiscal year 2023 to fiscal year 2024 due to increased utilization.

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.

In addition to the items mentioned above, total quality assurance fee (QAF) payments received and passed through to hospitals increased from $0.0 to $290.7 million 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.

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 increased by $76.3 million from income of $65.2 million in fiscal year 2023 to income of $141.5 million in fiscal year 2024. The increase 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 2023. 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.

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.

2023 and 2022 Results of Operations

CalOptima Health's fiscal year 2023 operating and non-operating income resulted in a $250.5 million increase in net position, $139.8 million more compared to a $110.7 million increase in fiscal year 2022. The following table reflects the changes in revenues and expenses for 2023 compared to 2022:

Table 2b: Revenues, Expenses, and Changes in Net Position for
Fiscal Years Ended June 30,
(Dollars in Thousands)

Results of Operations	2023	2022	Change from 2022 Amount	Change from 2022 Percentage
PREMIUM REVENUES	$ 4,239,833	$ 4,227,259	$ 12,574	0.3%
Total operating revenues	4,239,833	4,227,259	12,574	0.3%
MEDICAL EXPENSES	3,862,196	3,945,849	(83,653)	-2.1%
ADMINISTRATIVE EXPENSES	192,339	150,443	41,896	27.8%
Total operating expenses	4,054,535	4,096,292	(41,757)	-1.0%
OPERATING INCOME	185,298	130,967	54,331	41.5%
NONOPERATING REVENUES AND EXPENSES	65,198	(20,237)	85,435	-422.2%
Increase in net position	250,496	110,730	139,766	126.2%
NET POSITION, beginning of year	1,419,510	1,308,781	110,729	8.5%
NET POSITION, end of year	$ 1,670,006	$ 1,419,511	$ 250,495	17.6%

2023 and 2022 Operating Revenues

The increase in operating revenues of $12.6 million in fiscal year 2023 is primarily attributable to an increase in enrollment of 11.0 percent which resulted in additional revenue of $216.4 million and $50.0 million in revenue from programs, such as the HHIP, CalAIM IPP, and SBHIP. The increase in revenue is offset by net additional payables due to the State for the COVID-19, Proposition 56, and ECM risk corridor estimates.

2023 and 2022 Medical Expenses

Provider capitation, comprised of capitation payments to CalOptima Health's contracted health networks, decreased by 8.4 percent from fiscal year 2022 to fiscal year 2023. Capitated member enrollment accounted for approximately 73.4 percent of CalOptima Health's enrollment, averaging 690,882 members during fiscal year 2023 and approximately 75.0 percent of CalOptima Health's enrollment, averaging 644,579 members during fiscal year 2022. Included in the capitated environment are 232,786 or 33.7 percent and 212,078 or 32.9 percent members in a shared risk network for fiscal years 2023 and 2022, respectively. Shared risk networks receive capitation for professional services and are claims-based for hospital services.

Provider capitation expenses totaled $1,155.2 million in fiscal year 2023, compared to $1,226.2 million in fiscal year 2022. The decrease reflects adjustments for Proposition 56 estimated accruals due to an updated logic that impacted prior years.

Claims expenses to providers and facilities, including LTC services, increased by 14.6 percent from fiscal year 2022 to fiscal year 2023 due to increased utilization from higher enrollment.

Prescription drug expenses decreased by $348.5 million due to the State's transition of pharmacy benefits to Medi-Cal Fee-for-Service beginning January 1, 2022.

In addition to the items mentioned above, total QAF payments received and passed through to hospitals decreased from $146.4 million to $0.0 from fiscal year 2022 to fiscal year 2023 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.

2023 and 2022 Administrative Expenses

Total administrative expenses were $192.3 million in 2023 compared to $150.4 million in 2022. Overall administrative expenses increased by 27.8 percent or $41.9 million, primarily due to an increase in filled positions, cost of living and other salary adjustments, and adoption of the Government Accounting Standards Board (GASB) Statement No. 96 for Subscription-Based Information Technology Arrangements. In fiscal years 2023 and 2022, CalOptima Health's administrative expenses were 4.5 percent and 3.6 percent of total operating revenues, respectively.

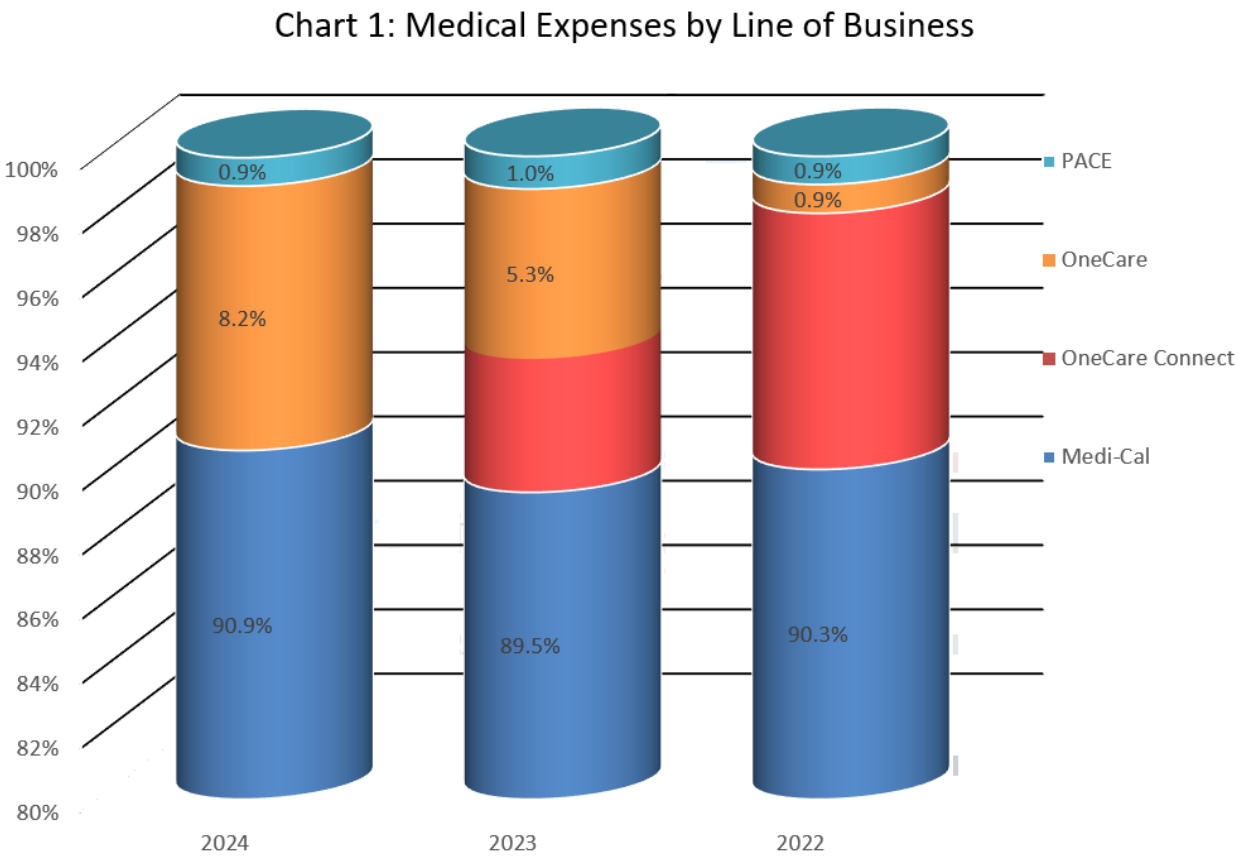
2023 and 2022 Non-Operating Revenues and Expenses

Non-operating revenue and expenses increased by $85.4 million from a loss of $20.2 million in fiscal year 2022 to income of $65.2 million in fiscal year 2023. The increase is driven primarily by net investment income in fiscal year 2023 of $90.4 million, an increase of $110.8 million from a net investment loss of $20.4 million in fiscal year 2022. The amount is offset by an increase in grant expenses of $25.5 million, from $121 thousand in fiscal year 2022 to $25.5 million in fiscal year 2023.

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.

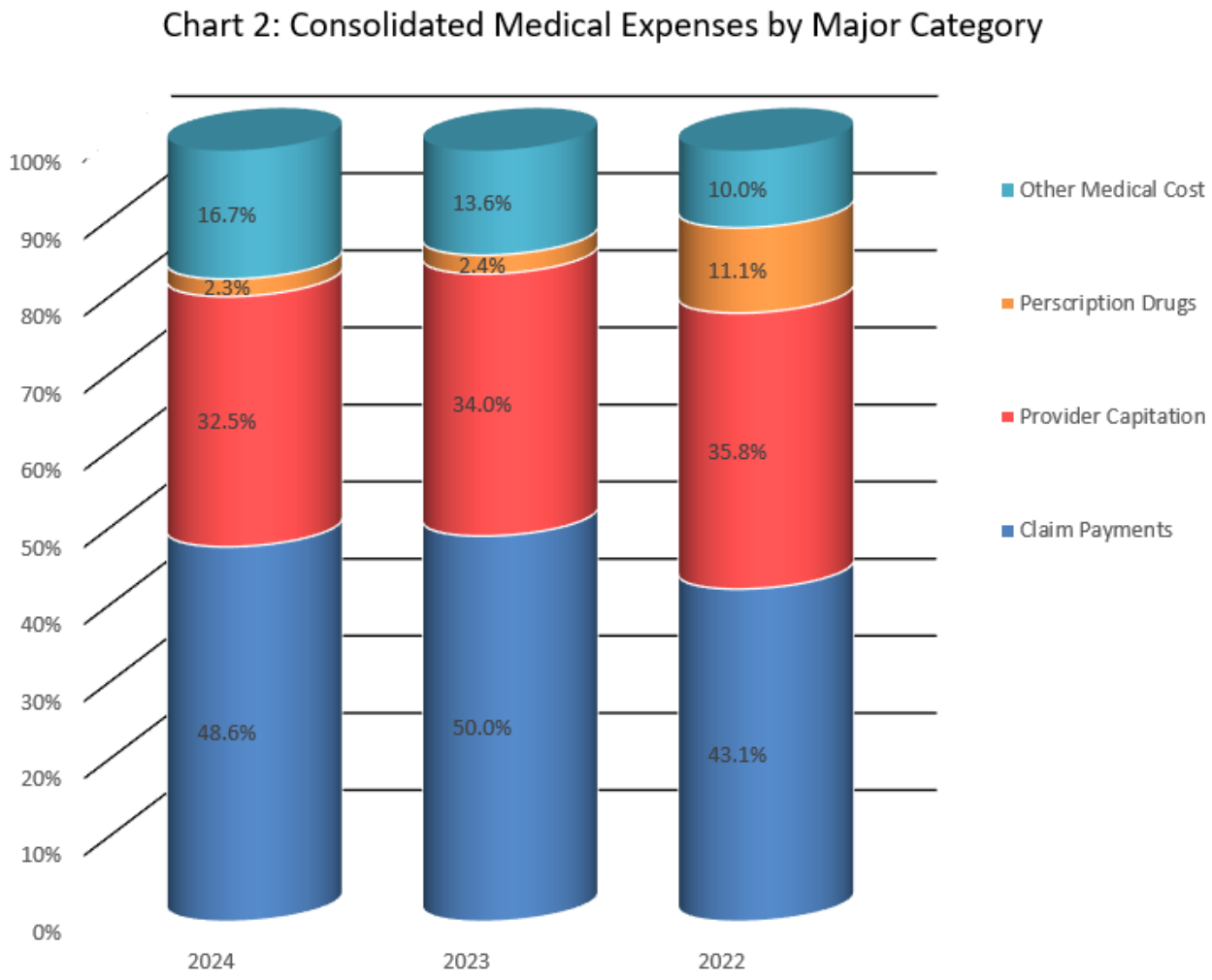
2024, 2023, and 2022 Medical Expenses by Line of Business

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.



2024, 2023, and 2022 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.

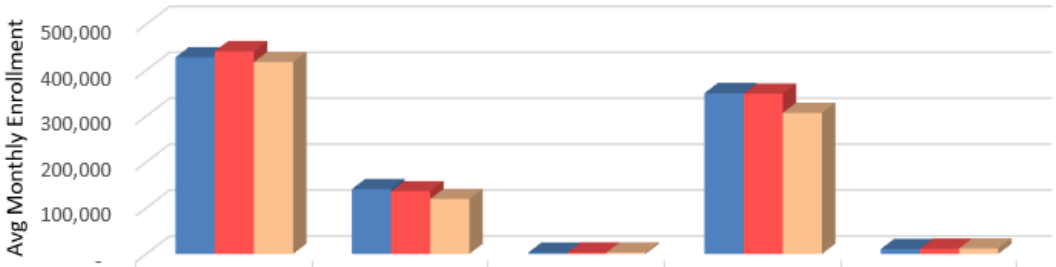


2024, 2023, and 2022 Enrollment

Medi-Cal

During fiscal year 2024, CalOptima Health served an average of 932,770 Medi-Cal members per month compared to an average of 940,893 members per month in 2023 and 859,290 members per month in 2022. The increase is attributed to the State's pause in Medi-Cal eligibility redetermination which began at the beginning of the COVID-19 pandemic in March 2020 and expired on May 11, 2023. The chart below displays a comparative view of average monthly membership by Medi-Cal aid category during 2024, 2023, and 2022.

Chart 3: Medi-Cal Membership by Aid Category
(Shown as Average Member Months)



	TANF	Disabled/ Aged	LTC	MCE	WCM
2024	428,244	141,185	2,751	350,000	10,589
2023	441,298	136,395	3,019	348,826	11,355
2022	417,709	119,679	3,149	306,910	11,843

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 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 of 65 years of age 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.

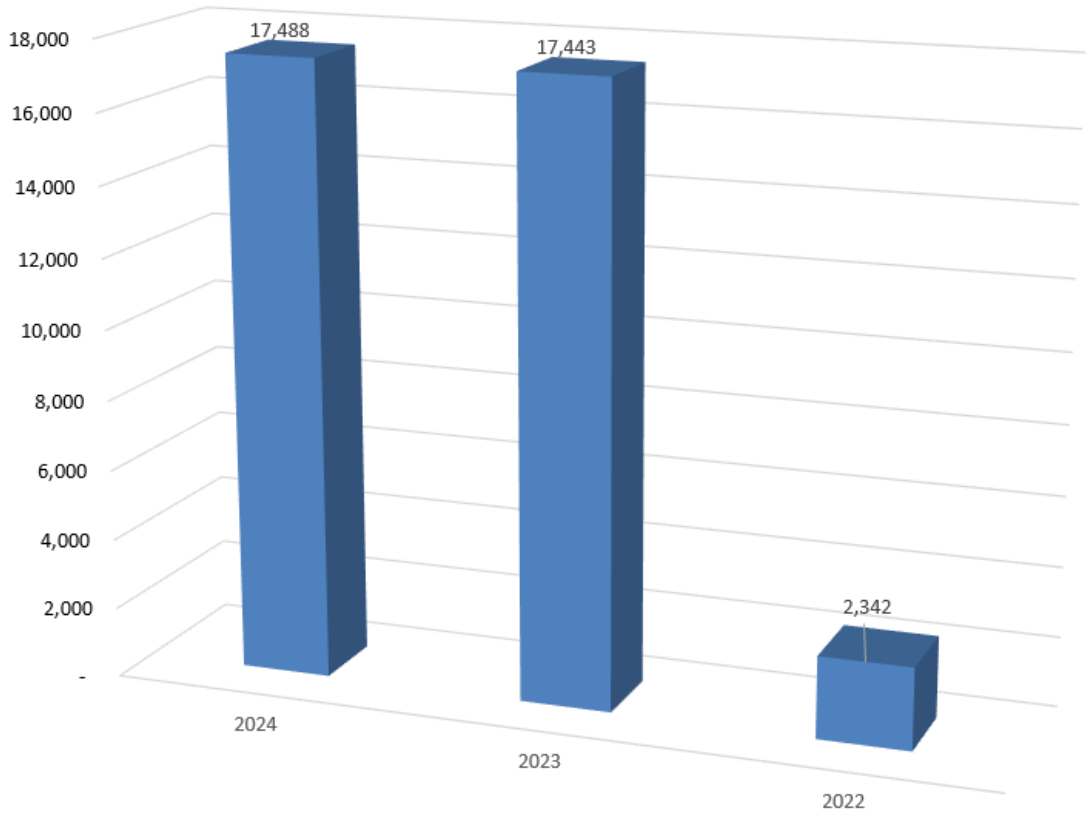
Medi-Cal Expansion (MCE) program includes adults without children, ages 19 to 64, who qualify based upon income, as required by the Patient Protection and Affordable Care Act (ACA).

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 17,488, 17,443, and 2,342 for the years ended June 30, 2024, 2023, and 2022, 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)



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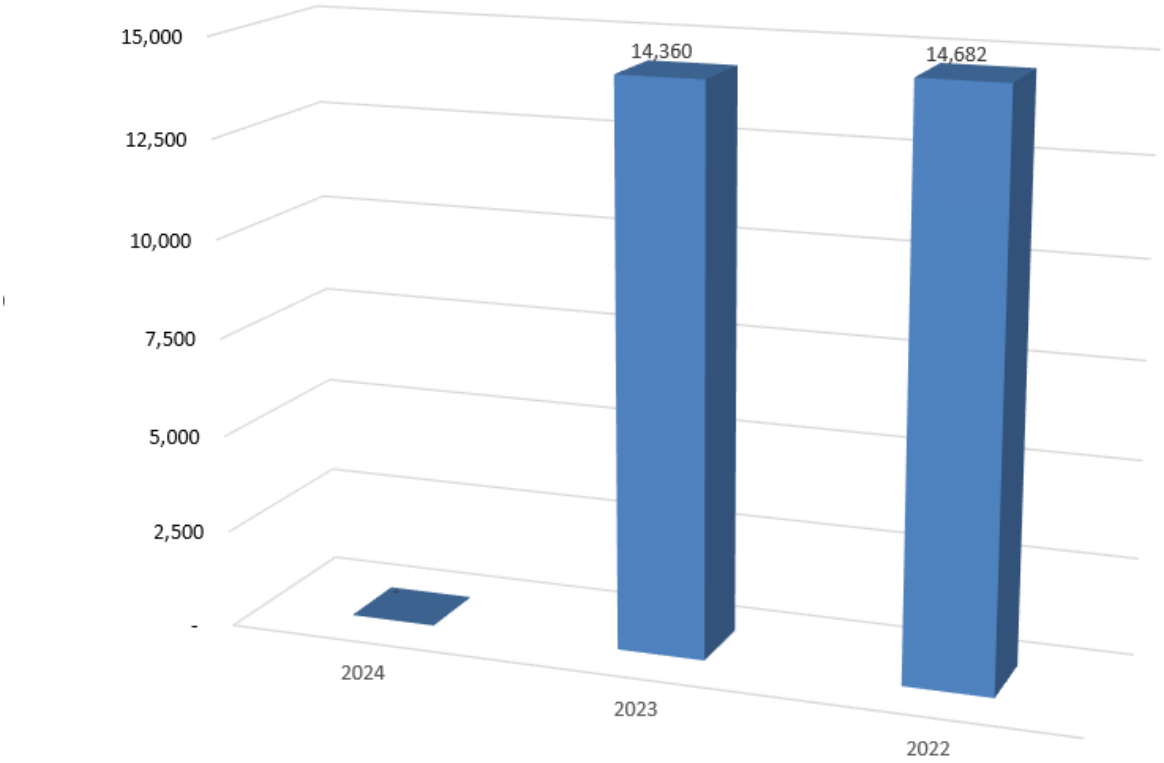
OneCare Connect

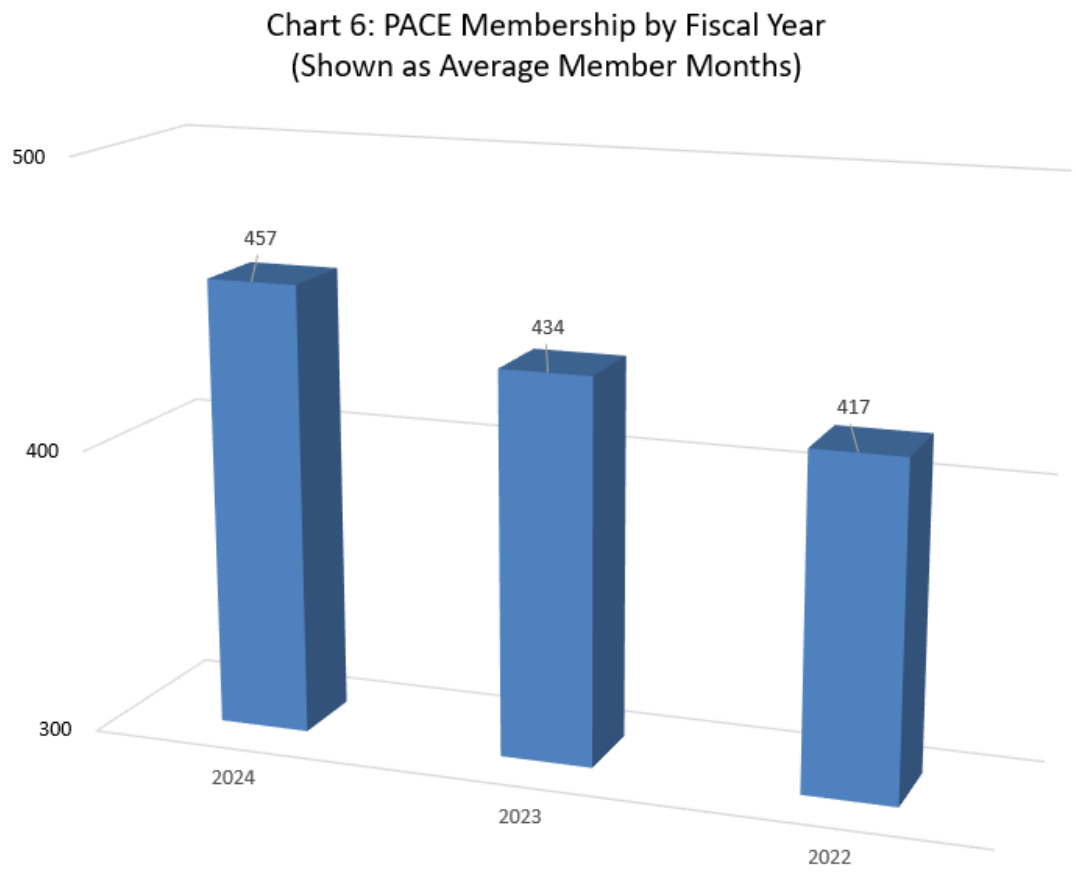
CalOptima Health launched the OneCare Connect program to serve dual eligible members in Orange County in July 2015. This program combines members' Medicare and Medi-Cal coverage and adds other benefits and supports. The average member months were 0, 14,360, and 14,682 for the fiscal years ended June 30, 2024, 2023, and 2022, respectively. For fiscal year 2023, the average member month was 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)



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 457, 434, and 417 for the fiscal years ended June 30, 2024, 2023, and 2022, respectively. The chart below displays the average member months for the past three years.



Economic Factors and the State's Fiscal Year 2024-25 Budget

On June 29, 2024, Governor Gavin Newsom signed the Fiscal Year (FY) 2024-25 state budget bill. The budget addressed a $46.8 billion deficit that resulted from significant revenue volatility and included a combination of solutions to close the gap, including spending reductions, use of reserves, funding shifts, delayed or paused spending, and payment deferrals to later years.

General Fund spending in the budget package was $211.5 billion, a decrease of $11.6 billion or 5.2 percent from FY 2023-24. The budget included $35 billion in General Fund spending for the Medi-Cal program, covering approximately 14.5 million beneficiaries in FY 2024-25.

Some major Medi-Cal initiatives included are:

- Continued investment in the Medi-Cal Transformation Initiative (i.e., CalAIM);
- Actions related to the Managed Care Organization tax, including revisions to the tax calculation methodology to increase revenues to support the Medi-Cal program, funding for some new targeted Medi-Cal provider rate increases to take effect January 1, 2025, and eliminated or delayed implementation for other targeted provider rate increases until January 1, 2026; and
- Continued funding for full-scope Medi-Cal coverage to all income eligible adults ages 26 to 49 regardless of immigration status.

The budget projected $212.1 billion in General Fund revenues and transfers in FY 2024-25, an increase of $22.7 billion or 12.0 percent compared to last fiscal year. The three largest General Fund taxes (i.e., personal income tax, sales and use tax, corporation tax) were projected to increase by 8.6 percent from FY 2023-24. The State is projected to end FY 2024-25 with $22.2 billion in total reserves.

DHCS routine annual audit – 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. As of this writing, CalOptima Health is awaiting the final findings report and formal request for corrective action.

DHCS State Supported Services (SSS) audit – 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. As of this writing, CalOptima Health is awaiting the final report.

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. DHCS concluded its review and as of this writing, CalOptima Health is awaiting the final findings report and formal request for corrective action.

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. As of this writing, CalOptima Health has completed its May 2, 2024, one (1) year response and is awaiting comments on the response.

CMS Program Audit – The Centers for Medicare & Medicaid Services (CMS) conducted a virtual, full-scope program audit of the OneCare and OneCare Connect programs in July 2021 through August 2021.

CalOptima Health received the final report from CMS in November 2021 that required several corrective actions. In January 2022, CMS confirmed acceptance of CalOptima Health's corrective actions for non-Immediate Corrective Action Required (ICAR) conditions and requested CalOptima Health to undergo an independent validation audit (IVA) by July 2022. In September 2022, CalOptima Health completed an independent validation audit as requested by CMS to demonstrate corrective actions were completed. In July 2023, CalOptima Health submitted a final revalidation report on two findings related to formulary administration and the Special Needs Plan Model of Care (SNP-MOC). On August 15, 2023, CMS notified CalOptima Health that CMS has determined CalOptima Health sufficiently corrected all conditions noted in the Final Audit Report and the 2021 Program Audit is closed.

CMS 1/3 Financial Audit – On September 21, 2023, CMS notified CalOptima Health that its OneCare (H5433) 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. As of this writing, CalOptima Health is awaiting the Final Report from the auditor. CalOptima Health has initiated the corrective action plan process for the findings noted.

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, CA 92868, or call (714) 347-3237.

MOSSADAMS

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, 2024 and 2023, 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, 2024 and 2023, 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
September 20, 2024

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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, 2024 and 2023

	2024	2023
CURRENT ASSETS		
Cash and cash equivalents	$ 527,999,319	$ 771,575,961
Investments	1,777,895,941	1,676,736,065
Premiums due from the State of California and CMS	461,899,906	380,839,598
Prepaid expenses and other	103,955,696	108,144,802
Total current assets	2,871,750,862	2,937,296,426
BOARD-DESIGNATED ASSETS AND RESTRICTED CASH		
Cash and cash equivalents	22,817,912	1,940,209
Investments	1,114,945,527	574,611,484
Restricted deposit	300,000	300,000
	1,138,063,439	576,851,693
CAPITAL ASSETS, NET	77,270,145	66,189,127
INTANGIBLE RIGHT-TO-USE SUBSCRIPTION ASSET, net	19,290,669	18,018,382
Total assets	4,106,375,115	3,598,355,628
DEFERRED OUTFLOWS OF RESOURCES		
Net pension	74,549,007	24,373,350
Other postemployment benefit	1,350,000	1,596,000
Total deferred outflows of resources	75,899,007	25,969,350
Total assets and deferred outflows of resources	$ 4,182,274,122	$ 3,624,324,978

See accompanying notes.

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Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health
Statements of Net Position (Continued)
June 30, 2024 and 2023

	2024	2023
CURRENT LIABILITIES		
Medical claims liability and capitation payable		
Medical claims liability	369,433,596	$ 333,993,756
Provider capitation and withholds	176,233,694	125,444,022
Accrued reinsurance costs to providers	7,511,531	4,312,093
Subscription liability	7,134,744	4,556,961
Due to the State of California and CMS	937,276,525	1,303,463,182
Unearned revenue	6,777,509	61,886,332
	1,504,367,599	1,833,656,346
Accounts payable and other	17,667,439	14,540,984
Accrued payroll and employee benefits and other	25,886,668	23,332,392
Total current liabilities	1,547,921,706	1,871,529,722
COMMUNITY REINVESTMENT	106,676,651	-
POSTEMPLOYMENT HEALTH CARE PLAN	17,370,000	18,975,000
SUBSCRIPTION LIABILITY, net of current portion	10,595,755	12,173,318
NET PENSION LIABILITY	45,981,359	40,465,145
Total liabilities	1,728,545,471	1,943,143,185
DEFERRED INFLOWS OF RESOURCES		
Net pension	2,248,445	3,387,516
Other postemployment benefit	6,398,000	7,788,000
Total deferred inflows of resources	8,646,445	11,175,516
NET POSITION		
Net investment in capital assets	78,830,315	~~115,592,667~~ 67,421,922
Restricted by legislative authority	127,852,909	107,969,096
Unrestricted	2,238,398,982	~~1,446,444,514~~ 1,494,615,259
Total net position	2,445,082,206	1,670,006,277
Total liabilities, deferred inflows of resources, and net position	$ 4,182,274,122	$ 3,624,324,978

See accompanying notes.

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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, 2024 and 2023

	2024	2023
REVENUES		
Premium revenues	$ 5,372,963,895	$ 4,239,833,266
Total operating revenues	5,372,963,895	4,239,833,266
OPERATING EXPENSES		
Medical expenses		
Claims expense to providers and facilities	2,094,723,338	1,815,097,808
Provider capitation	1,477,805,330	1,275,685,079
Other medical	528,360,774	367,744,574
OneCare Connect	-	160,125,649
PACE	39,737,377	39,133,937
OneCare	369,285,675	204,408,932
Total medical expenses	4,509,912,494	3,862,195,979
Administrative expenses		
Salaries, wages, and employee benefits	149,096,246	129,037,210
Supplies, occupancy, insurance, and other	39,389,249	31,742,817
Purchased services	22,407,022	15,551,299
Depreciation and amortization	8,008,630	8,114,542
Professional fees	10,609,407	7,892,802
Total administrative expenses	229,510,554	192,338,670
Total operating expenses	4,739,423,048	4,054,534,649
OPERATING INCOME	633,540,847	185,298,617
NON-OPERATING REVENUES		
Net investment income and other	174,598,247	89,740,819
Grant expense	(33,282,237)	(25,530,071)
Rental income, net of related expenses	219,072	987,046
Total non-operating revenues	141,535,082	65,197,794
Increase in net position	775,075,929	250,496,411
NET POSITION, beginning of year	1,670,006,277	1,419,509,866
NET POSITION, end of year	$ 2,445,082,206	$ 1,670,006,277

See accompanying notes.

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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, 2024 and 2023

	2024	2023
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation payments received and other	$ 4,870,608,107	$ 4,607,104,404
Payments to providers and facilities	(4,313,806,893)	(3,896,885,154)
Payments to vendors	(56,642,960)	(62,171,613)
Payments to employees	(195,089,484)	(125,545,812)
Net cash provided by operating activities	305,068,770	522,501,825
CASH FLOWS USED IN CAPITAL AND RELATED FINANCING ACTIVITIES		
Payments on subscription lease obligations	(8,592,862)	(5,414,341)
Purchases of capital assets	(19,216,010)	(6,499,838)
Net cash used in capital and related financing activities	(27,808,872)	(11,914,179)
CASH FLOWS USED IN INVESTING ACTIVITIES		
Investment income received	201,775,923	125,584,618
Purchases of securities	(21,016,264,492)	(46,933,516,529)
Sales of securities	20,326,715,194	46,269,973,906
Payments of grants to providers	(33,282,237)	(25,530,071)
Collections related to rental income	219,072	987,046
Net cash used in investing activities	(520,836,540)	(562,501,030)
Net change in cash and cash equivalents	(243,576,642)	(51,913,384)
CASH AND CASH EQUIVALENTS, beginning of year	771,575,961	823,489,345
CASH AND CASH EQUIVALENTS, end of year	$ 527,999,319	$ 771,575,961
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating income	$ 633,540,847	$ 185,298,617
ADJUSTMENT TO RECONCILE OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Depreciation	15,680,860	10,719,510
Changes in assets and liabilities		
Premiums due from the State of California and CMS	(81,060,308)	24,352,789
Prepaid expenses and other	4,189,106	(13,880,348)
Medical claims liability	35,439,840	32,141,035
Provider capitation and withholds	50,789,672	(67,770,606)
Accrued reinsurance costs to providers	3,199,438	940,396
Due to the State of California and CMS	(366,186,657)	289,081,118
Unearned revenue	(55,108,823)	53,837,231
Accounts payable and other	110,578,033	4,290,685
Accrued payroll and employee benefits and other	2,554,276	3,764,852
Postemployment health care plan	(2,749,000)	(2,207,000)
Net pension liability	(45,798,514)	1,933,546
Net cash provided by operating activities	$ 305,068,770	$ 522,501,825

See accompanying notes.

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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 agency 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 901,300 and 970,600 Medi-Cal beneficiaries for the years ended June 30, 2024 and 2023, 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 17,300 and 17,700 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2024 and 2023, respectively.

In July 2015, CalOptima Health began offering the OneCare Connect Cal Medi Connect Plan, a Medicare-Medicaid Plan, via a contract with CMS and DHCS. OneCare Connect served an average of 14,360 members during the period July 1, 2022 through December 31, 2022 and approximately 14,400 during the year-ended June 30, 2022. The OneCare Connect Program ended on December 31, 2022. Starting January 1, 2023, CalOptima Health transitioned all subscribers from OneCare Connect to the OneCare Plan. Enrollment in the OneCare Connect Program at December 31, 2022 was 14,385.

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 55 years of age or older members 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 Tangible Net Equity (TNE), which CalOptima Health exceeded as of June 30, 2024 and 2023.

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 fiscal 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.

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 May 2024 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 3.0 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

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, premium 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 $27,304,000 and $32,197,000 as of June 30, 2024 and 2023, respectively, and are included in provider capitation and withholds on the statements of net position. During the years ended June 30, 2024 and 2023, CalOptima Health incurred approximately $1,463,590,000 and $1,312,969,000, 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, 2024 and 2023, related to the capitation withhold arrangements, quality incentive payments, and risk-share provisions were approximately $176,234,000 and $125,444,000, 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, 2024 and 2023.

Community reinvestment – CalOptima Health is required to commit a percentage of net position towards 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. As of June 30, 2024, in accordance with State contracts, the balance of the community reinvestment was estimated at approximately $51,400,000 and the balance of the quality achievement was estimated at approximately $55,200,000, for a total estimated accrual of approximately $106,677,000. As the community reinvestment and quality achievement requirement was effective January 1, 2024, no accrual was necessary as of June 30, 2023.

Accrued compensated absences – 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 accrued and recorded in accordance with GASB Codification Section C60 and are included in accrued payroll and employee benefits.

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, including restricted capital assets, net of accumulated depreciation, and is reduced by the outstanding balances of any bonds, notes, or other borrowings that are attributable (if any) 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 law or regulations of other governments. It also pertains to constraints imposed by law or 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 nonoperating 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 nonoperating 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 $966,461,000 and $376,821,000 related to retroactive capitation rate adjustments based on receipt of new information from DHCS during the years ended June 30, 2024 and 2023, respectively.

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.

CalOptima Health was historically subject to DHCS requirements to meet the minimum 85 percent medical loss ratio (MLR) for the Medi-Cal Expansion population per the Affordable Care Act (ACA). On April 5, 2023, CalOptima Health received written confirmation from DHCS that the expansion MLRs for the period of January 1, 2014, through June 30, 2016, were considered closed and final. As a result, CalOptima Health released the expansion MLR liability of approximately $135,390,000 during the year ended June 30, 2023. The amount was recorded within premium revenues on the accompanying statements of revenues, expenses, and changes in net position. In March 2023, CalOptima Health was notified that the Organization was not required to remit any MLR payments to DHCS, nor will DHCS make any additional payment for fiscal year 2018. DHCS has communicated that MCE MLRs are no longer required after June 2018 pending CMS final approval.

Premium revenue and related net receivables as a percent of the totals were as follows as of June 30:

	2024		2023	
	Revenue	%	Revenue	%
Revenue				
Medi-Cal	$ 4,918,009,421	91.5%	$ 3,809,323,101	89.8%
OneCare	407,480,604	7.6%	214,353,873	5.1%
OneCare Connect	-	0.0%	172,148,803	4.1%
PACE	47,473,870	0.9%	44,007,489	1.0%
	$ 5,372,963,895	100.0%	$ 4,239,833,266	100.0%

	2024		2023	
	Receivables	%	Receivables	%
Receivables				
Medi-Cal	$ 438,045,910	94.8%	$ 355,725,299	93.4%
OneCare Connect	19,720,151	4.3%	22,601,354	5.9%
PACE	4,133,845	0.9%	2,512,945	0.7%
	$ 461,899,906	100.0%	$ 380,839,598	100.0%

Effective January 1, 2023, the OneCare Connect program ended and the OneCare Connect enrollment transitioned to the OneCare program. Any residual revenue and expenses related to One Care Connect are recorded as part of the One Care revenue and expenses on the statement of revenues, expenses, and changes in net position.

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 $147,059,000 and $121,159,000 during the years ended June 30, 2024 and 2023, respectively. Under the agreement, approximately $145,317,000 and $119,622,000 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, 2024 and 2023, 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, which 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 $2,918,000 and $5,698,000 as of June 30, 2024 and 2023, respectively, is included in unearned revenues in the statements of net position.

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 four types: (1) Private Hospital Directed Payment Program (PHDP), (2) Public Hospital Enhanced Payment Program (EPP), (3) Public Hospital Quality Incentive Program (QIP), and (4) Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP). Under the Directed Payment program, approximately $314,307,000 and $293,811,000 of the funds that were received from DHCS were passed through to hospitals as requested by DHCS during the years ended June 30, 2024 and 2023, 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 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, 2024 and 2023, the Part D payable balance was approximately $8,808,000 and $1,882,000, 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, 2024 and 2023, the Part D receivable balance was approximately $52,167,000 and $51,860,000, 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.

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, 2024 and 2023, were calculated. CalOptima Health recognized premium tax expense of approximately $657,657,000 and $92,241,000 as a reduction of premium revenues in the statements of revenue, expenses, and changes in net position for the years ended June 30, 2024 and 2023, respectively. As of June 30, 2024, CalOptima Health's MCO tax liability was approximately $153,920,000, and is included in the due to the State of California and CMS line item on the accompanying statements of net position. As the MCO tax expired on December 31, 2022, and was not approved for extension until December 15, 2023, CalOptima Health did not record a MCO tax liability as of June 30, 2023.

Risk corridors – During the year ended June 30, 2021, CalOptima Health's contract with DHCS was subject to a risk corridor for the Managed Long-Term Services and Supports program for the period of July 1, 2015 through June 30, 2017. Additionally, 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 is 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. The State also implemented an Enhanced Care Management (ECM) risk corridor for the period of January 1, 2022 through December 31, 2022, and was extended through December 31, 2024 and Unsatisfactory Immigration Status (UIS) risk corridor for the period of January 2024 to December 2024.

CalOptima Health also participates in the Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) risk corridor for the period of July 1, 2018 through June 30, 2019 and all subsequent years. 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, 2024 and 2023, CalOptima Health recognized a liability of approximately $304,789,000 and $962,366,000, 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, 2024, the increase to premium revenue was approximately $599,501,700 and for year ended June 30, 2023, the reduction of premium revenue was approximately $575,761,000, related to the risk corridors, which is included in premium revenues on the statements of revenues, expenses, and changes in net position.

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 subscription-based information technology arrangements (SBITA). Short term SBITAs, which have a maximum possible term of 12 months or less, 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.

Note 3 – Cash, Cash Equivalents, and Investments

Cash and investments are reported in the statements of net position as follows as of June 30:

	2024	2023
Current assets		
Cash and cash equivalents	$ 527,999,319	$ 771,575,961
Investments	1,777,895,941	1,676,736,065
Board-designated assets and restricted cash		
Cash and cash equivalents	22,817,912	1,940,209
Investments	1,114,945,527	574,611,484
Restricted deposit	300,000	300,000
	$ 3,443,958,699	$ 3,025,163,719

Board-designated assets and restricted cash are available for the following purposes as of June 30:

	2024	2023
Board-designated assets and restricted cash		
Contingency reserve fund	$ 1,137,763,439	$ 576,551,693
Restricted deposit with DMHC	300,000	300,000
	$ 1,138,063,439	$ 576,851,693

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, 2024 and 2023, 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.

Interest rate risk – In accordance with its annual investment policy (investment policy), CalOptima Health manages its exposure to decline 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, 2024 and 2023, CalOptima Health's investments, including cash equivalents, had the following modified duration:

	June 30, 2024			
		Investment Maturities (in Years)		
Investment Type	Fair Value	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	-	-
	3,337,311,446	$ 955,395,590	$ 2,381,915,856	$ -
Accrued interest receivable	22,012,384			
	$ 3,359,323,830			

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		Investment Maturities (in Years)		
Investment Type	Fair Value	Less Than 1	1–5	More Than 5
U.S. Treasury notes	$ 652,372,690	$ 334,436,427	$ 317,936,263	$ -
U.S. Agency notes	294,565,404	-	294,565,404	-
Corporate bonds	606,478,662	151,600,486	454,878,176	-
Asset-backed securities	167,709,021	41,290,805	126,418,216	-
Mortgage-backed securities	352,525,833	24,026,927	328,498,906	-
Municipal bonds	69,679,079	26,904,673	42,774,406	-
Supranational	9,707,125	-	9,707,125	-
Commercial paper	34,824,599	34,824,599	-	-
Certificates of deposit	48,082,917	48,082,917	-	-
Cash equivalents	666,834,439	666,834,439	-	-
Cash	7,274,284	7,274,284	-	-
	2,910,054,053	$ 1,335,275,557	$ 1,574,778,496	$ -
Accrued interest receivable	15,402,218			
	$ 2,925,456,271			

Investment 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 include 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:

	2024	2023
Asset-backed securities	$ 282,066,505	$ 167,709,021
Mortgage-backed securities	338,957,054	352,525,833
	$ 621,023,559	$ 520,234,854

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 an "A."

As of June 30, 2024, following are the credit ratings of investments and cash equivalents:

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

As of June 30, 2023, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt from Disclosure	Rating as of Year-End					
				AAA	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	$ 709,754,225	N/A	$ 709,754,225	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	472,401,379	N/A	472,401,379	-	-	-	-	-	-
Corporate bonds	610,956,872	A-	-	48,288,393	8,241,443	108,468,276	189,593,093	154,798,256	101,567,411
Asset-backed securities	167,997,222	AA-	-	165,939,194	2,058,028	-	-	-	-
Mortgage-backed securities	355,150,030	AAA	-	355,150,030	-	-	-	-	-
Municipal bonds	107,477,262	A-	-	66,287,078	26,428,815	10,727,556	1,007,344	1,568,179	1,458,290
Supranational	9,779,429	AAA	-	9,779,429	-	-	-	-	-
Certificates of deposit	48,838,522	A1/P1	-	48,838,522	-	-	-	-	-
Commercial paper	435,827,044	A1/P1	-	420,914,269	14,912,775	-	-	-	-
Money market mutual funds	7,274,286	AAA	-	7,274,286	-	-	-	-	-
Total	$ 2,925,456,271		$ 1,182,155,604	$ 1,122,471,201	$ 51,641,061	$ 119,195,832	$ 190,600,437	$ 156,366,435	$ 103,025,701

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 to no more than 5 percent 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 percent may be invested in one money market mutual. As of June 30, 2024 and 2023, 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 transparency 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.

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, 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
	$ 840,085,184	$ 2,030,750,524	$ -	$ 2,870,835,708

	Investment Assets at Fair Value as of June 30, 2023			
	Level 1	Level 2	Level 3	Total
U.S. Treasury notes	$ 652,372,690	$ -	$ -	$ 652,372,690
U.S. Agency notes	-	294,565,404	-	294,565,404
Corporate bonds	-	606,478,662	-	606,478,662
Asset-backed securities	-	167,709,021	-	167,709,021
Mortgage-backed securities	-	352,525,833	-	352,525,833
Municipal bonds	-	69,679,079	-	69,679,079
Supranational	-	9,707,125	-	9,707,125
Commercial paper	-	34,824,599	-	34,824,599
Certificates of deposit	-	48,082,917	-	48,082,917
	$ 652,372,690	$ 1,583,572,640	$ -	$ 2,235,945,330

Note 4 – Capital Assets

Capital assets 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
	14,955,728	$14,705,241	-	(6,159,826)	23,501,143
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
	114,472,422	4,510,769	(770,550)	6,159,826	124,372,467
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
	63,239,023	7,559,702	(195,260)	-	70,603,465
Total depreciable assets, net	51,233,399	(3,048,933)	(575,290)	6,159,826	53,769,002
Capital assets, net	$ 66,189,127	$11,656,308	$ (575,290)	$ -	$ 77,270,145

Capital asset activity during the year ended June 30, 2023, consisted of the following:

	June 30, 2022	Additions	Retirements	Transfers	June 30, 2023
Capital assets not being depreciated					
Land	$ 11,912,499	$ -	$ -	$ -	$ 11,912,499
Construction in progress	3,507,883	6,499,838	-	(6,964,492)	3,043,229
	15,420,382	6,499,838	-	(6,964,492)	14,955,728
Capital assets being depreciated					
Furniture and equipment	8,314,975	-	(81,528)	703,414	8,936,861
Computers and software	39,307,282	-	(7,882,165)	4,930,402	36,355,519
Leasehold improvements	5,059,409	-	(2,400)	239,717	5,296,726
Building	63,092,357	-	(300,000)	1,090,959	63,883,316
	115,774,023	-	(8,266,093)	6,964,492	114,472,422
Less: accumulated depreciation for					
Furniture and equipment	6,909,422	523,445	(81,528)	-	7,351,339
Computers and software	33,589,790	4,070,843	(7,868,331)	-	29,792,302
Leasehold improvements	5,017,129	37,220	(2,400)	-	5,051,949
Building	18,814,022	2,529,411	(300,000)	-	21,043,433
	64,330,363	7,160,919	(8,252,259)	-	63,239,023
Total depreciable assets, net	51,443,660	(7,160,919)	(13,834)	6,964,492	51,233,399
Capital assets, net	$ 66,864,042	$ (661,081)	$ (13,834)	$ -	$ 66,189,127

The Organization recognized depreciation expense of approximately $7,421,000 and $7,053,000 during the years ended June 30, 2024 and 2023, respectively. During the years ended June 30, 2024 and 2023, depreciation expense of approximately $139,000 and $108,000, respectively, was 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:

	2024	2023
Claims payable or pending approval	$ 38,371,849	$ 52,909,889
Provisions for IBNR claims	331,061,747	281,083,867
	$ 369,433,596	$ 333,993,756

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.

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:

	2024	2023
Beginning balance	$ 333,993,756	$ 301,852,721
Incurred		
Current	2,394,253,671	2,099,911,537
Prior	(91,115,588)	(65,796,666)
	2,303,138,083	2,034,114,871
Paid		
Current	2,024,213,932	1,765,917,781
Prior	243,484,311	236,056,055
	2,267,698,243	2,001,973,836
Ending balance	$ 369,433,596	$ 333,993,756

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 $91,116,000 and $65,797,000 for the fiscal years ended June 30, 2024 and 2023, 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.

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, 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, CA 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), a 3-Year Final Compensation Period (Section 20037), Pre-Retirement Death Benefits to Continue After Remarriage of Survivor (Section 21551), as well as 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, 2024, 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
Monthly benefits as a % of eligible compensation	1.092%-2.418%	1.0% to 2.5%
Required employee contribution rates	7.00%	7.75%
Required employer contribution rates	9.17%	9.17%

The following is a summary of plan participants:

	June 30, 2024	June 30, 2023
Active employees	1,599	1,583
Retirees and beneficiaries		
Receiving benefits	255	220
Deferred retirement benefits		
Terminated employees	1,332	1,222
Surviving spouses	5	5
Beneficiaries	2	1

Contributions – Section 20814(c) of the California PERL requires that the employer contribution rates for all public employers are determined on an annual basis by the actuary and shall be 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 is 7.75 percent (Classic and PEPRA New Members) and 7.0 percent (Classic Members) of annual pay for the years ended June 30, 2024 and 2023, respectively. The employer's contribution rate is 9.17 percent and 8.41 percent of annual payroll for the years ended June 30, 2024 and 2023, respectively. On October 3, 2023, CalOptima Health made an additional discretionary payment (ADP) of approximately $50.0 million to reduce the unfunded accrued liability and future required contributions. This ADP is not reflected in CalOptima Health's valuation report for the measurement period ending on June 30, 2023.

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, 2023 (the measurement date), the total pension liability was determined by rolling forward the June 30, 2022 total pension liability. Total pension liabilities were based on the following actuarial methods and assumptions as of June 30, 2023 and June 30, 2022:

Valuation date	June 30, 2022
Measurement date	June 30, 2023
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	7.0% 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

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 are as follows:

	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
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

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2022	$ 240,018,505	$ 239,440,651	$ 577,854
Changes during the year			
Service cost	17,958,280	-	17,958,280
Interest on the total pension liability	17,450,590	-	17,450,590
Changes of benefit terms	-	-	-
Differences between expected and actual experience	(1,930,719)	-	(1,930,719)
Changes of assumptions	8,006,529	-	8,006,529
Contributions from the employer	-	11,688,269	(11,688,269)
Contributions from employees	-	8,634,939	(8,634,939)
Net investment income	-	(18,576,662)	18,576,662
Benefit payments, including refunds of employee contributions	(4,332,714)	(4,332,714)	-
Administrative expenses	-	(149,157)	149,157
Net changes during the year	37,151,966	(2,735,325)	39,887,291
Balance at June 30, 2023	$ 277,170,471	$ 236,705,326	$ 40,465,145

Discount rate and long-term rate of return – The discount rate used to measure the total pension liability was 6.90 percent. 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 plan'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.

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

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 1 percentage point lower or 1 percentage point higher than the current rate:

	June 30, 2024		
	Discount Rate -1% 5.90%	Current Discount Rate 6.90%	Discount Rate +1% 7.90%
Net pension liability	$ 100,402,066	$ 45,981,359	$ 2,195,114

	June 30, 2023		
	Discount Rate -1% 5.90%	Current Discount Rate 6.90%	Discount Rate +1% 7.90%
Net pension liability	$ 88,612,198	$ 40,465,145	$ 1,732,263

Pension expense and deferred outflows/inflows of resources related to pensions – CalOptima Health recognized pension expense of approximately $20,970,000 and $17,255,000 for the years ended June 30, 2024 and 2023, respectively. As of June 30, 2024 and 2023, CalOptima Health recognized deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	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	-
	$ 74,549,007	$ (2,248,445)

	June 30, 2023	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions from employers subsequent to the measurement date	$ 2,375,580	$ -
Net differences between projected and actual earnings on plan investments	12,718,340	-
Changes in assumptions	7,732,138	(1,202,155)
Differences between expected and actual experiences	1,547,292	(2,185,361)
	$ 24,373,350	$ (3,387,516)

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, 2024. 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,	
2024	$ 4,150,398
2025	3,521,390
2026	9,171,760
2027	2,116,544
2028	1,296,914
Thereafter	165,907
	$ 20,422,913

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, 2024 and 2023, 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). All regular and limited-term employees are eligible to participate in the PARS Plan. The current PARS Plan design does not require employee contributions. CalOptima Health makes discretionary employer contributions to the PARS Plan as authorized by the Board of Directors. Vesting occurs over 16 quarters of service. For the years ended June 30, 2024 and 2023, CalOptima Health contributed approximately $6,587,000 and $5,777,000, 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.

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 a 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 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, 2023
Measurement period	July 1, 2022 - June 30, 2023
Valuation date	January 1, 2024

Covered employees – The following numbers of participants were covered by the benefit terms as of June 30:

	2024	2023
Inactives currently receiving benefits	78	76
Active employees	60	65
Inactives entitled to but not yet receiving benefits	2	3
Total	140	144

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 $522,000, including $468,000 in premium payments for retirees and $54,000 for implied subsidies, for the year ended June 30, 2024. CalOptima Health contributed approximately $528,000, which related to implied subsidies, for the year ended June 30, 2023. The most recent actuarial report for the Plan was June 30, 2023. As of that point, the actuarial accrued liability and unfunded actuarial accrued liability for benefits were approximately $17,370,000.

Actuarial assumptions – CalOptima Health's total postemployment retirement liability was measured as of June 30, 2023, and the assumptions used to calculate the total postemployment retirement liability was 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	3.65% at June 30, 2023, Bond Buyer 20 Index 3.54% at June 30, 2022, 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 3.65 percent for June 30, 2023. 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 were as follows:

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

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Balance at June 30, 2022	$ 22,178,000
Changes for the year	
Service cost	668,000
Interest	487,000
Contributions – employer	(529,000)
Assumption changes	(3,829,000)
Net changes	(3,203,000)
Balance at June 30, 2023	$ 18,975,000

Sensitivity of the net OPEB liability to changes in the discount rate – The following presents the net OPEB liability as of June 30, 2024, as well as what the net OPEB liability would be if it were calculated using a discount rate that is 1 percentage point lower or 1 percentage point higher than the current discount rate:

	1% Decrease (2.65%)	Current Rate (3.65%)	1% Increase (4.65%)
Total OPEB liability	$ 19,841,000	$ 17,370,000	$ 15,316,000

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, 2024, as well as what the net OPEB liability would be if it were calculated using health care cost trend rates that are 1 percentage point lower or 1 percentage point higher than the current health care cost trend rates:

	1% Decrease	Current Rate	1% Increase
Total OPEB liability	$ 15,102,000	$ 17,370,000	$ 20,166,000

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For the years ended June 30, 2024 and 2023 CalOptima Health recognized a reduction to OPEB expense of approximately $2,227,000 and $1,679,000, respectively. As of June 30, 2024 and 2023, the reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	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	$ 1,350,000	$ 6,398,000

	June 30, 2023	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ -	$ 2,867,000
Changes in assumptions	1,068,000	4,921,000
Employer contributions made subsequent to measurement date	528,000	-
Total	$ 1,596,000	$ 7,788,000

The $522,000 reported as deferred outflows of resources related to contributions subsequent to the June 30, 2023 measurement date will be recognized as a reduction of the total post-employment retirement liability during the fiscal year ended June 30, 2024.

Other amounts reported as deferred inflows of resources related to OPEB will be recognized as expense as follows:

Years Ending June 30,	
2025	$ (3,573,000)
2026	(1,440,000)
2027	(557,000)
	$ (5,570,000)

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, 2024 and 2023, of $127,852,909 and $107,969,096, respectively. As of June 30, 2024 and 2023, the Organization is in compliance with its TNE requirement.

The Act further required that CalOptima Health maintain a restricted deposit in the amount of $300,000. CalOptima Health met this requirement as of June 30, 2024 and 2023.

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,	
2025	$ 631,929
2026	653,016
2027	710,210
2028	768,055
2029	791,097
Thereafter	1,678,549
	$ 5,232,856

Rental expense under operating leases was approximately $713,000 for the years ended June 30, 2024 and 2023, respectively.

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.

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, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Note 12 –Subscription-based Information Technology Arrangements

CalOptima Health has several subscription contracts that expire at various dates through 2028 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 percent to 8 percent to determine the present value of the subscription liabilities. The amortization on the intangible subscription asset amounted to approximately $7,500,000 and $3,600,000 during the years ended June 30, 2024 and 2023, respectively, and is included in depreciation and amortization on the statement of revenues, expenses and changes in net position. As of June 30, 2024 and 2023, CalOptima Health recognized approximately $19,291,000 and $18,018,000, respectively, in intangible right-to-use subscription assets which is comprised of the intangible right-to-use subscription asset cost of approximately $30,372,000 and $21,733,000, respectively, less accumulated amortization of approximately $11,081,000 and $3,714,000, respectively. As of June 30, 2024 and 2023 CalOptima Health recognized approximately $17,730,000 and $16,730,000, respectively, in SBITA subscription liabilities.

The future subscription payments under SBITA agreements as of June 30, 2024 are as follows:

	Subscriptions		
	Principal	Interest	Total
Years Ending June 30,			
2025	$ 8,125,577	$ 988,688	$ 9,114,265
2026	6,201,136	569,961	6,771,097
2027	4,911,800	196,803	5,108,603
2028	311,281	1,922	313,203
Total undiscounted cash flows	19,549,794	1,757,374	21,307,168
Less: present value discount			3,576,669
Total subscription liabilities			$ 17,730,499

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

	Years Ended June 30,									
	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015
Total pension liability										
Service cost	$ 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	$ 6,464,105
Interest	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	5,661,111
Differences between expected and actual experience	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	(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)	(1,326,364)
Net change in total pension liability	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	10,798,852
Total pension liability – beginning	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	72,912,613
Total pension liability – ending	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	83,711,465
Plan fiduciary net position										
Contributions – employer	$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	3,119,804
Contributions – employee	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	3,385,296
Net investment income	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	12,062,654
Benefit payments, including refunds of employee contributions	(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)	(1,326,364)
Other changes in fiduciary net position	(174,062)	(149,157)	(181,370)	(225,629)	(98,234)	(530,428)	(143,264)	(54,828)	(101,246)	-
Net change in fiduciary net position	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	17,241,390
Plan fiduciary net position – beginning	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	65,410,580
Plan fiduciary net position – ending	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 net pension liability – ending	$ 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	$ 1,059,495
Plan fiduciary net position as percentage of the total liability	85.50%	85.40%	99.76%	85.57%	85.51%	85.40%	82.38%	86.28%	93.23%	98.73%
Covered-employee payroll	$ 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	$ 40,940,556
Plan net pension liability as a percentage of covered-employee payroll	38.11%	36.84%	0.56%	31.22%	29.61%	27.52%	31.29%	22.50%	11.74%	2.59%

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,									
	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015
Actuarially determined contributions	$ 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	$ 3,119,804
Contributions in relation to the actuarially determined contribution	(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)	(3,119,804)
Contribution deficiency (excess)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Covered-employee payroll	$ 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	$ 40,940,556
Contributions as a percentage of covered-employee payroll	11.62%	10.64%	10.34%	9.80%	9.46%	8.85%	6.53%	5.52%	5.45%	7.62%

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

	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	$ 472,000	$ 668,000	$ 1,149,000	$ 811,000	$ 832,000	$ 867,000	$ 1,012,000
Interest	679,000	487,000	718,000	922,000	977,000	900,000	770,000
Benefit changes	-	-	-	-	-	-	-
Actual vs. expected experience	(3,332,000)	-	(6,241,000)	-	(1,072,000)	-	-
Assumption changes	1,104,000	(3,829,000)	(4,514,000)	4,623,000	938,000	(1,067,000)	(2,923,000)
Benefit payments	(528,000)	(529,000)	(544,000)	(570,000)	(556,000)	(560,000)	(572,000)
Net changes	(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)	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)	$ 17,370,000	$ 18,975,000	$ 22,178,000	$ 31,610,000	$ 25,824,000	$ 24,705,000	$ 24,565,000
Total OPEB liability	$ 17,370,000	$ 18,975,000	$ 22,178,000	$ 31,610,000	$ 25,824,000	$ 24,705,000	$ 24,565,000
Covered employee payroll	8,536,000	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	203.5%	214.1%	243.0%	371.3%	309.2%	303.1%	268.9%

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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, 2024 and 2023

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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, 2024, 2023, and 2022. 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, 2024, 2023, and 2022:

Key Operating Indicators	2024	2023	2022
Members (at end of fiscal period)			
Medi-Cal program	901,303	970,590	897,134
OneCare	17,253	17,687	2,668
OneCare Connect	-	-	14,415
PACE	496	439	429
Average member months			
Medi-Cal program	932,770	940,893	859,290
OneCare	17,488	17,443	2,342
OneCare Connect	-	14,360	14,682
PACE	457	434	417
Operating revenues (in millions)	$ 5,372	$ 4,239	$ 4,227
Operating expenses (in millions)			
Medical expenses	4,510	3,862	3,946
Administrative expenses	230	192	150
Operating income (in millions)	$ 633	$ 184	$ 131
Operating revenues PMPM (per member per month)	$ 471	$ 369	$ 402
Operating expenses PMPM			
Medical expenses PMPM	395	336	375
Administrative expenses PMPM	20	17	14
Operating income PMPM	$ 56	$ 16	$ 13
Medical loss ratio	84%	91%	93%
Administrative expenses ratio	4.3%	4.5%	3.6%
Premium tax revenue and expenses not included above			
Operating revenues (in millions)	$ 658	$ 90	$ 168
Administrative expenses (in millions)	$ 658	$ 92	$ 166

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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, 2024, 2023, and 2022, and the results of its operations for the fiscal years ended June 30, 2024, 2023, and 2022. 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), and Multipurpose Senior Services Program (MSSP).

- 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 addresses CalOptima Health's overall program activities. CalOptima Health's Medi-Cal program accounted for 91.5 percent, 89.8 percent, and 90.0 percent of its annual revenues during fiscal years 2024, 2023, and 2022, respectively. CalOptima Health's OneCare program accounted for 7.6 percent, 5.1 percent, and 0.9 percent of its annual revenues during fiscal years 2024, 2023, and 2022, respectively. CalOptima Health's OneCare Connect program accounted for 0.0 percent, 4.1 percent, and 8.1 percent of its annual revenues during fiscal years 2024, 2023, and 2022, respectively. All other programs in aggregate accounted for 0.9 percent, 1.1 percent, and 1.0 percent of CalOptima Health's annual revenues during fiscal years 2024, 2023, and 2022, respectively.

During Fiscal Year 2024, new laws and State contract changes impacted CalOptima Health's membership and financial statements. Beginning January 1, 2024, a new law in California provides full-scope Medi-Cal eligibility to adults ages 26 through 49, regardless of immigration status. The enrollment increase from Adult Expansion program was offset by the transition of Kaiser members 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.

2024 and 2023 Financial Highlights

As of June 30, 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.

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 1a: Condensed Statements of Net Position as of June 30,
(Dollars in Thousands)

Financial Position	2024	2023	Change from 2023 Amount	Change from 2023 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	100.0%
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	$ 4,182,274	$ 3,624,324	$ 557,950	15.4%
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)	100.0%
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	67,422	11,408	16.9%
Restricted by legislative authority	127,853	107,969	19,884	18.4%
Unrestricted	2,238,399	1,494,615	743,784	49.8%
Total net position	2,445,082	1,670,006	775,076	46.4%
Total liabilities, deferred inflows of resources, and net position	$ 4,182,274	$ 3,624,324	$ 557,950	15.4%

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 June 30, 2024, the Enhanced Care Management (ECM) risk corridor for the period of January 1, 2022 through June 30, 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.

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.

Statutory and 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 Tangible Net Equity (TNE) Requirement. In addition to the existing Board-designated reserve, the Board designated $100.0 million in total funding for homeless health initiatives (HHI) on April 4, 2019. On September 1, 2022, the Board approved a reallocation of the remaining $40.1 million from HHI to the state Housing and Homelessness Incentive Program (HHIP) initiatives. As of June 30, 2024, the total Board designated funding has been allocated.

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 1.0 to 1.10 times the requirement and CalOptima Health's 2024 reserves level stands at 1.03 times the TNE. CalOptima Health's total reserve level as of June 30, 2023, was at 1.78 times the monthly average consolidated capitation revenue.

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).

2023 and 2022 Financial Highlights

As of June 30, 2023 and 2022, total assets and deferred outflows of resources were approximately $3,624.3 million and $3,025.6 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately $1,670.0 million and $1,419.5 million, respectively.

Net position increased by approximately $250.5 million, or 17.6 percent, during fiscal year 2023 and increased by approximately $110.7 million, or 8.5 percent, during fiscal year 2022.

Table 1b: Condensed Statements of Net Position as of June 30,
(Dollars in Thousands)

Financial Position	2023	2022	Change from 2022 Amount	Change from 2022 Percentage
ASSETS				
Current assets	$ 2,937,296	$ 2,337,407	$ 599,889	25.7%
Board-designated assets and restricted cash	576,852	611,428	(34,576)	-5.7%
Capital assets, net	66,189	66,864	(675)	-1.0%
Intangible right-to-use subscription asset	18,018	18,018	-	0.0%
Total assets	3,598,355	2,525,826	1,072,529	42.5%
DEFERRED OUTFLOWS OF RESOURCES	25,969	9,626	16,343	169.8%
Total assets and deferred outflows of resources	$ 3,624,324	$ 3,025,586	$ 598,738	19.8%
LIABILITIES				
Current liabilities	$ 1,871,529	$ 1,551,389	$ 320,140	20.6%
Other liabilities	59,440	22,756	36,684	161.2%
Subscription liability, net of current portion	12,173	141	12,032	0.0%
Total liabilities	1,943,142	1,574,286	368,856	23.4%
DEFERRED INFLOWS OF RESOURCES	11,176	31,790	(20,614)	-64.8%
NET POSITION				
Net investment in capital assets	67,422	66,772	650	1.0%
Restricted by legislative authority	107,969	107,346	623	0.6%
Unrestricted	1,494,615	1,245,392	249,223	20.0%
Total net position	1,670,006	1,419,510	250,496	17.6%
Total liabilities, deferred inflows of resources, and net position	$ 3,624,324	$ 3,025,586	$ 598,738	19.8%

Current assets increased $599.9 million from $2,337.4 million in 2022 to $2,937.3 million in 2023, primarily in cash and investments. Cash and investments had a net increase of $575.8 million primarily from increased enrollment and premium capitation rates. Current liabilities increased $320.1 million from $1,551.4 million in 2022 to $1,871.5 million in 2023 driven primarily by payables due to the State for the COVID-19 risk corridor for the period of July 1, 2019 through April 30, 2023, the Proposition 56 risk corridors for the period of January 1, 2021 through June 30, 2023, and the ECM risk corridor for the period of January 1, 2022 through June 30, 2023. In May 2023, the State finalized the bridge period (July 1, 2019 through December 31, 2020) Proposition 56 risk corridor and a payment was remitted to the State in June 2023 in the amount of $74.5 million.

Board-designated assets and restricted cash decreased by $34.6 million and increased by $3.6 million in fiscal years 2023 and 2022, respectively, primarily driven by changes to the portfolio's valuation. In addition to the existing Board-designated reserve, the Board designated $100.0 million in total funding for HHI on April 4, 2019. On September 1, 2022, the Board approved a reallocation of the remaining $40.1 million from HHI to the state HHIP initiatives. As of June 30, 2023, the balance of the HHI reserve was $21.0 million.

The Board's policy is to augment the rest of the Board-designated assets to provide a desired level of funds between 1.4 months and 2.0 months in consolidated capitation revenue to meet future contingencies. CalOptima Health's reserve level of Tier One and Tier Two investment portfolios as of June 30, 2023 and 2022, is at 1.78 and 1.75 times the monthly average consolidated capitation revenue, respectively.

CalOptima Health is also required to maintain a $300,000 restricted deposit as a part of the Act.

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 2a: 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	Change from 2023 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	4,509,912	3,862,196	647,716	16.8%
ADMINISTRATIVE EXPENSES	229,511	192,339	37,172	19.3%
Total operating expenses	4,739,423	4,054,535	684,888	16.9%
OPERATING INCOME	633,541	185,298	448,243	241.9%
NONOPERATING REVENUES AND EXPENSES	141,535	65,198	76,337	117.1%
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 is attributable to increased premium capitation rates, newly eligible UIS members, and $93.0 million in revenue from various State programs such as HHIP, Student Behavioral Health Incentive Program (SBHIP), and California Advancing and Innovating Medi-Cal (CalAIM) Incentive Payment Program (IPP). The increase in operating revenue is 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 net increase in payables to the State of $47.3 million for the Proposition 56, UIS, and ECM risk corridors.

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 79.0 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 are 187,207 or 28.5 percent and 232,786 or 33.7 percent 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 long-term care (LTC) services, increased by 15.4 percent from fiscal year 2023 to fiscal year 2024 due to increased utilization.

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.

In addition to the items mentioned above, total quality assurance fee (QAF) payments received and passed through to hospitals increased from $0.0 to $290.7 million 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.

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 increased by $76.3 million from income of $65.2 million in fiscal year 2023 to income of $141.5 million in fiscal year 2024. The increase 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 2023. 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.

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.

2023 and 2022 Results of Operations

CalOptima Health's fiscal year 2023 operating and non-operating income resulted in a $250.5 million increase in net position, $139.8 million more compared to a $110.7 million increase in fiscal year 2022. The following table reflects the changes in revenues and expenses for 2023 compared to 2022:

Table 2b: Revenues, Expenses, and Changes in Net Position for
Fiscal Years Ended June 30,
(Dollars in Thousands)

Results of Operations	2023	2022	Change from 2022 Amount	Change from 2022 Percentage
PREMIUM REVENUES	$ 4,239,833	$ 4,227,259	$ 12,574	0.3%
Total operating revenues	4,239,833	4,227,259	12,574	0.3%
MEDICAL EXPENSES	3,862,196	3,945,849	(83,653)	-2.1%
ADMINISTRATIVE EXPENSES	192,339	150,443	41,896	27.8%
Total operating expenses	4,054,535	4,096,292	(41,757)	-1.0%
OPERATING INCOME	185,298	130,967	54,331	41.5%
NONOPERATING REVENUES AND EXPENSES	65,198	(20,237)	85,435	-422.2%
Increase in net position	250,496	110,730	139,766	126.2%
NET POSITION, beginning of year	1,419,510	1,308,781	110,729	8.5%
NET POSITION, end of year	$ 1,670,006	$ 1,419,511	$ 250,495	17.6%

2023 and 2022 Operating Revenues

The increase in operating revenues of $12.6 million in fiscal year 2023 is primarily attributable to an increase in enrollment of 11.0 percent which resulted in additional revenue of $216.4 million and $50.0 million in revenue from programs, such as the HHIP, CalAIM IPP, and SBHIP. The increase in revenue is offset by net additional payables due to the State for the COVID-19, Proposition 56, and ECM risk corridor estimates.

2023 and 2022 Medical Expenses

Provider capitation, comprised of capitation payments to CalOptima Health's contracted health networks, decreased by 8.4 percent from fiscal year 2022 to fiscal year 2023. Capitated member enrollment accounted for approximately 73.4 percent of CalOptima Health's enrollment, averaging 690,882 members during fiscal year 2023 and approximately 75.0 percent of CalOptima Health's enrollment, averaging 644,579 members during fiscal year 2022. Included in the capitated environment are 232,786 or 33.7 percent and 212,078 or 32.9 percent members in a shared risk network for fiscal years 2023 and 2022, respectively. Shared risk networks receive capitation for professional services and are claims-based for hospital services.

Provider capitation expenses totaled $1,155.2 million in fiscal year 2023, compared to $1,226.2 million in fiscal year 2022. The decrease reflects adjustments for Proposition 56 estimated accruals due to an updated logic that impacted prior years.

Claims expenses to providers and facilities, including LTC services, increased by 14.6 percent from fiscal year 2022 to fiscal year 2023 due to increased utilization from higher enrollment.

Prescription drug expenses decreased by $348.5 million due to the State's transition of pharmacy benefits to Medi-Cal Fee-for-Service beginning January 1, 2022.

In addition to the items mentioned above, total QAF payments received and passed through to hospitals decreased from $146.4 million to $0.0 from fiscal year 2022 to fiscal year 2023 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.

2023 and 2022 Administrative Expenses

Total administrative expenses were $192.3 million in 2023 compared to $150.4 million in 2022. Overall administrative expenses increased by 27.8 percent or $41.9 million, primarily due to an increase in filled positions, cost of living and other salary adjustments, and adoption of the Government Accounting Standards Board (GASB) Statement No. 96 for Subscription-Based Information Technology Arrangements. In fiscal years 2023 and 2022, CalOptima Health's administrative expenses were 4.5 percent and 3.6 percent of total operating revenues, respectively.

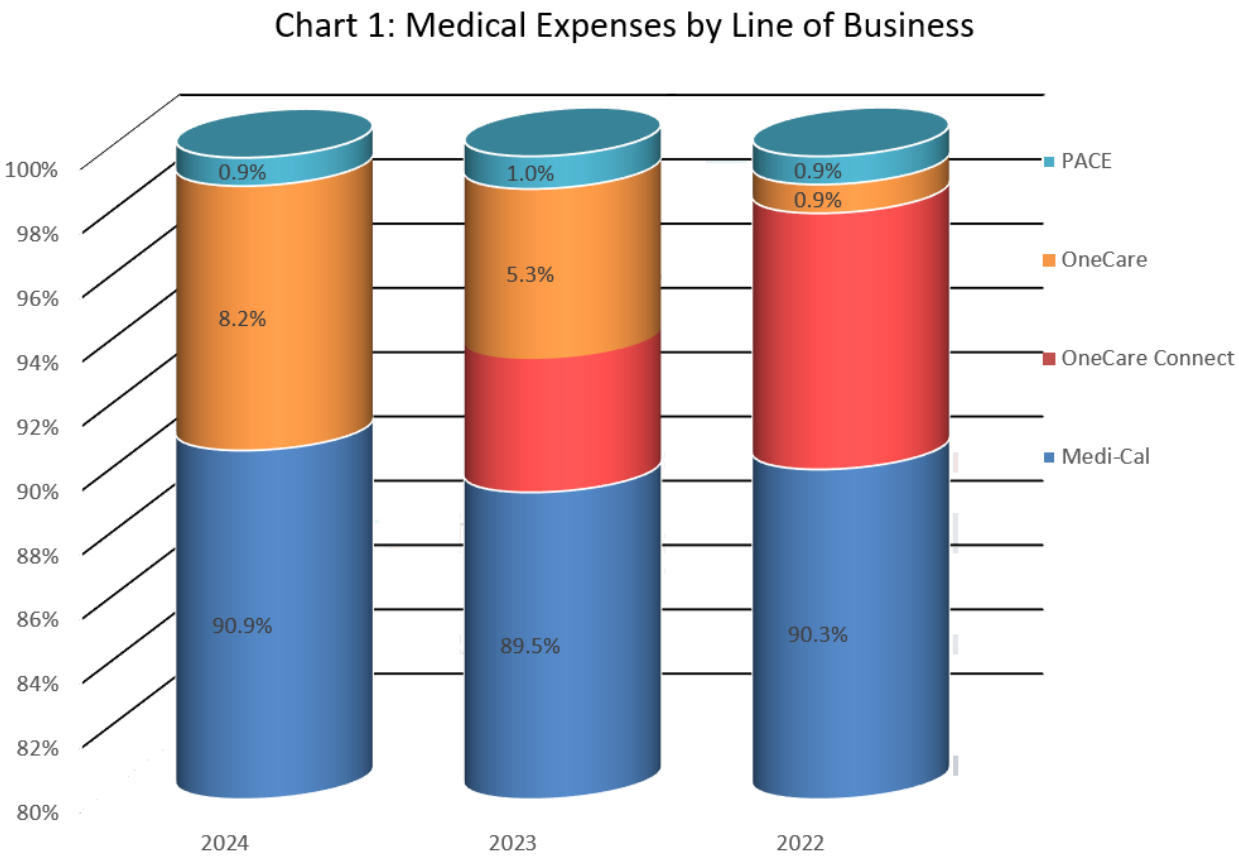
2023 and 2022 Non-Operating Revenues and Expenses

Non-operating revenue and expenses increased by $85.4 million from a loss of $20.2 million in fiscal year 2022 to income of $65.2 million in fiscal year 2023. The increase is driven primarily by net investment income in fiscal year 2023 of $90.4 million, an increase of $110.8 million from a net investment loss of $20.4 million in fiscal year 2022. The amount is offset by an increase in grant expenses of $25.5 million, from $121 thousand in fiscal year 2022 to $25.5 million in fiscal year 2023.

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.

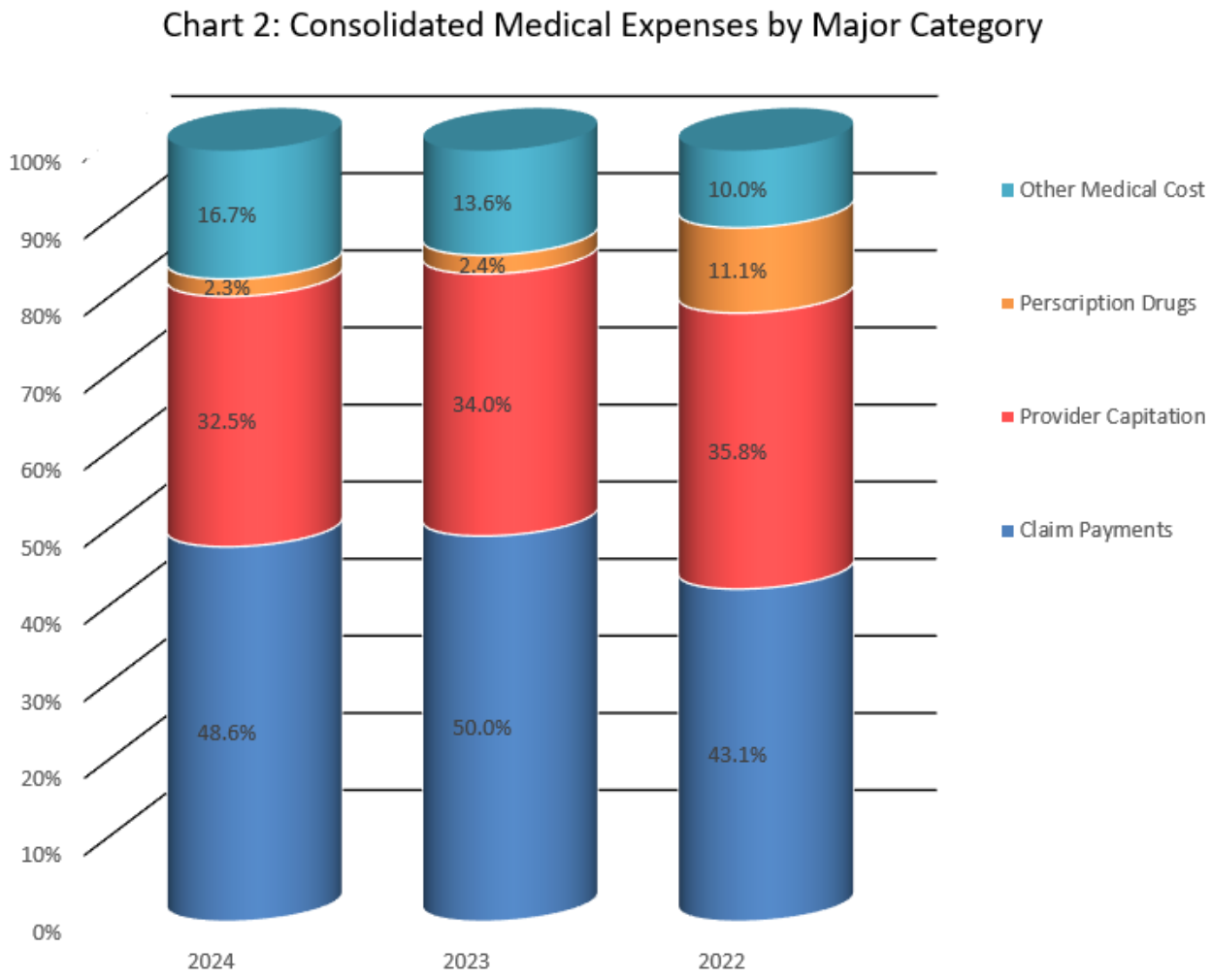
2024, 2023, and 2022 Medical Expenses by Line of Business

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.



2024, 2023, and 2022 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.

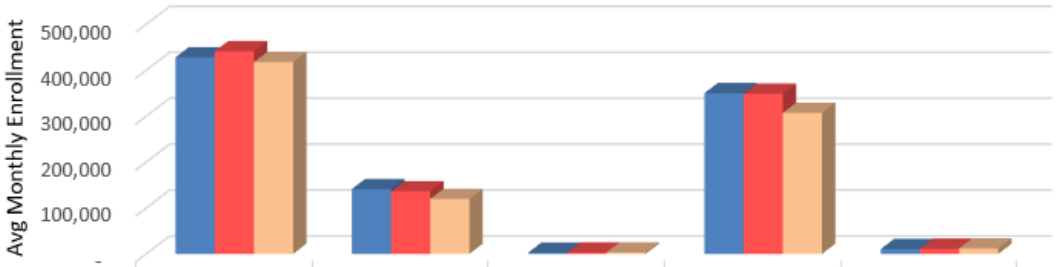


2024, 2023, and 2022 Enrollment

Medi-Cal

During fiscal year 2024, CalOptima Health served an average of 932,770 Medi-Cal members per month compared to an average of 940,893 members per month in 2023 and 859,290 members per month in 2022. The increase is attributed to the State's pause in Medi-Cal eligibility redetermination which began at the beginning of the COVID-19 pandemic in March 2020 and expired on May 11, 2023. The chart below displays a comparative view of average monthly membership by Medi-Cal aid category during 2024, 2023, and 2022.

Chart 3: Medi-Cal Membership by Aid Category
(Shown as Average Member Months)



	TANF	Disabled/ Aged	LTC	MCE	WCM
2024	428,244	141,185	2,751	350,000	10,589
2023	441,298	136,395	3,019	348,826	11,355
2022	417,709	119,679	3,149	306,910	11,843

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 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 of 65 years of age 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.

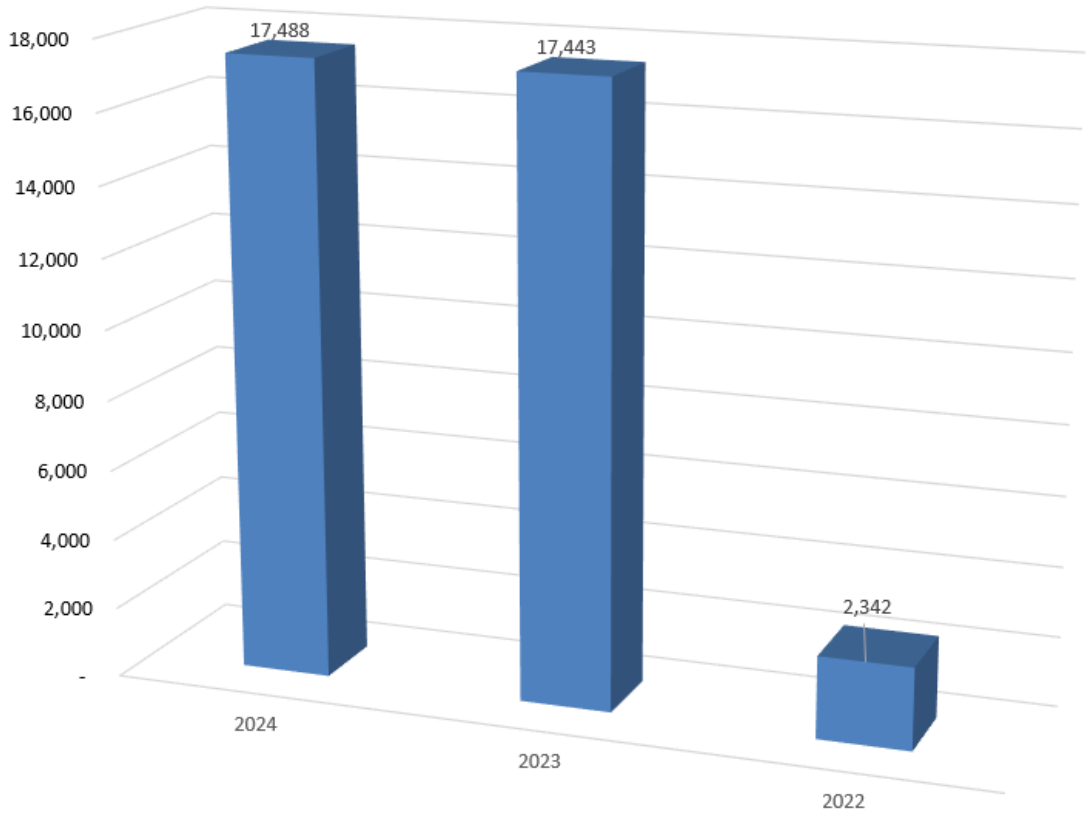
Medi-Cal Expansion (MCE) program includes adults without children, ages 19 to 64, who qualify based upon income, as required by the Patient Protection and Affordable Care Act (ACA).

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 17,488, 17,443, and 2,342 for the years ended June 30, 2024, 2023, and 2022, 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)



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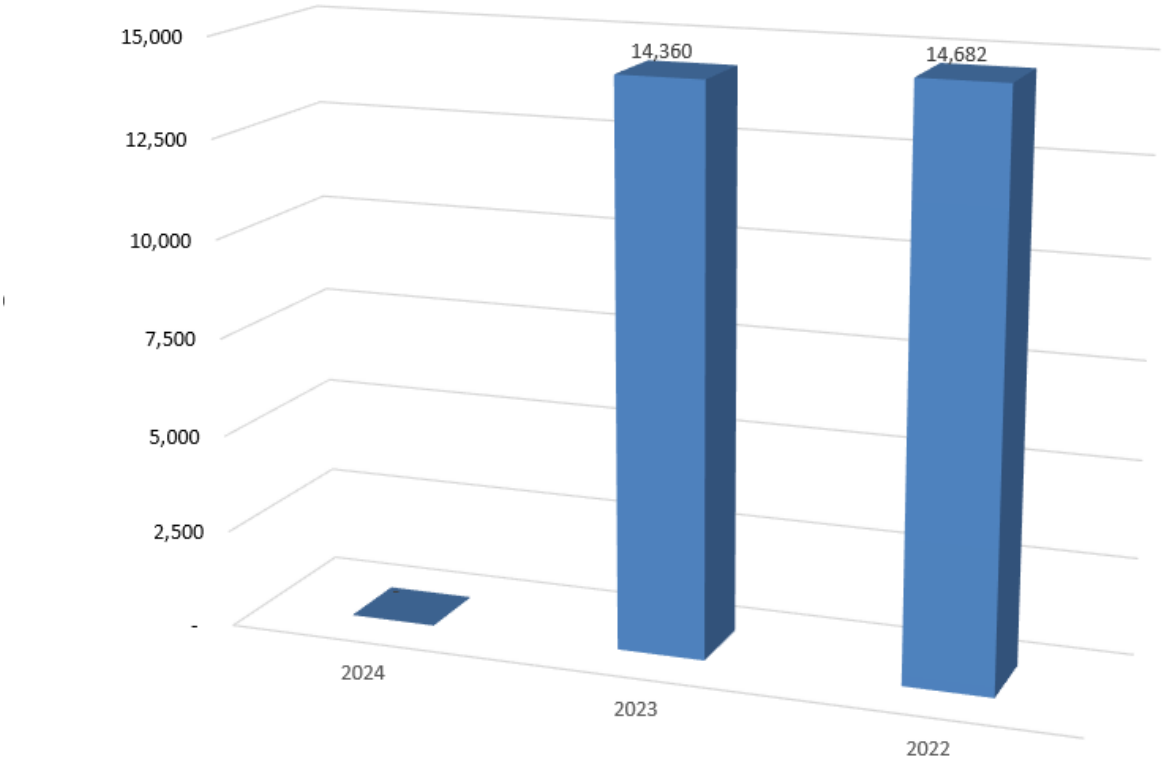
OneCare Connect

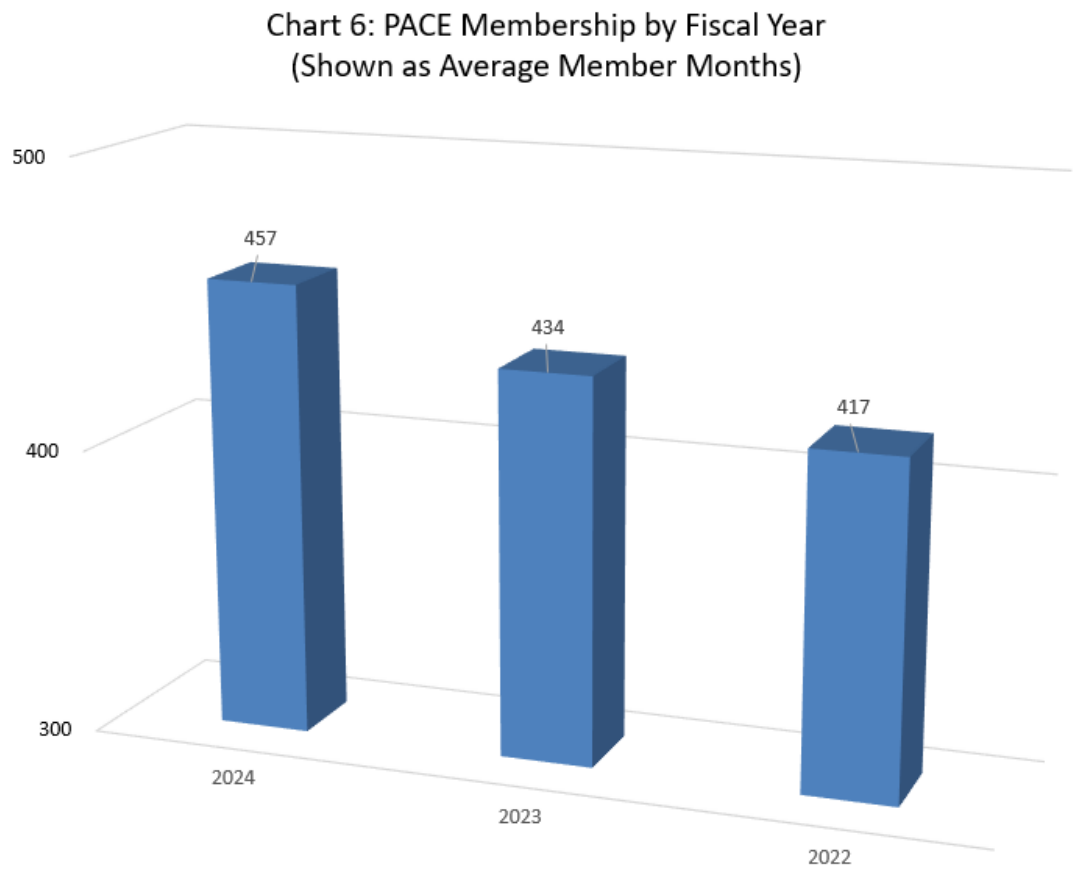
CalOptima Health launched the OneCare Connect program to serve dual eligible members in Orange County in July 2015. This program combines members' Medicare and Medi-Cal coverage and adds other benefits and supports. The average member months were 0, 14,360, and 14,682 for the fiscal years ended June 30, 2024, 2023, and 2022, respectively. For fiscal year 2023, the average member month was 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)



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 457, 434, and 417 for the fiscal years ended June 30, 2024, 2023, and 2022, respectively. The chart below displays the average member months for the past three years.



Economic Factors and the State's Fiscal Year 2024-25 Budget

On June 29, 2024, Governor Gavin Newsom signed the Fiscal Year (FY) 2024-25 state budget bill. The budget addressed a $46.8 billion deficit that resulted from significant revenue volatility and included a combination of solutions to close the gap, including spending reductions, use of reserves, funding shifts, delayed or paused spending, and payment deferrals to later years.

General Fund spending in the budget package was $211.5 billion, a decrease of $11.6 billion or 5.2 percent from FY 2023-24. The budget included $35 billion in General Fund spending for the Medi-Cal program, covering approximately 14.5 million beneficiaries in FY 2024-25.

Some major Medi-Cal initiatives included are:

- Continued investment in the Medi-Cal Transformation Initiative (i.e., CalAIM);
- Actions related to the Managed Care Organization tax, including revisions to the tax calculation methodology to increase revenues to support the Medi-Cal program, funding for some new targeted Medi-Cal provider rate increases to take effect January 1, 2025, and eliminated or delayed implementation for other targeted provider rate increases until January 1, 2026; and
- Continued funding for full-scope Medi-Cal coverage to all income eligible adults ages 26 to 49 regardless of immigration status.

The budget projected $212.1 billion in General Fund revenues and transfers in FY 2024-25, an increase of $22.7 billion or 12.0 percent compared to last fiscal year. The three largest General Fund taxes (i.e., personal income tax, sales and use tax, corporation tax) were projected to increase by 8.6 percent from FY 2023-24. The State is projected to end FY 2024-25 with $22.2 billion in total reserves.

DHCS routine annual audit – 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. As of this writing, CalOptima Health is awaiting the final findings report and formal request for corrective action.

DHCS State Supported Services (SSS) audit – 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. As of this writing, CalOptima Health is awaiting the final report.

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. DHCS concluded its review and as of this writing, CalOptima Health is awaiting the final findings report and formal request for corrective action.

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. As of this writing, CalOptima Health has completed its May 2, 2024, one (1) year response and is awaiting comments on the response.

CMS Program Audit – The Centers for Medicare & Medicaid Services (CMS) conducted a virtual, full-scope program audit of the OneCare and OneCare Connect programs in July 2021 through August 2021.

CalOptima Health received the final report from CMS in November 2021 that required several corrective actions. In January 2022, CMS confirmed acceptance of CalOptima Health's corrective actions for non-Immediate Corrective Action Required (ICAR) conditions and requested CalOptima Health to undergo an independent validation audit (IVA) by July 2022. In September 2022, CalOptima Health completed an independent validation audit as requested by CMS to demonstrate corrective actions were completed. In July 2023, CalOptima Health submitted a final revalidation report on two findings related to formulary administration and the Special Needs Plan Model of Care (SNP-MOC). On August 15, 2023, CMS notified CalOptima Health that CMS has determined CalOptima Health sufficiently corrected all conditions noted in the Final Audit Report and the 2021 Program Audit is closed.

CMS 1/3 Financial Audit – On September 21, 2023, CMS notified CalOptima Health that its OneCare (H5433) 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. As of this writing, CalOptima Health is awaiting the Final Report from the auditor. CalOptima Health has initiated the corrective action plan process for the findings noted.

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, CA 92868, or call (714) 347-3237.

MOSSADAMS

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, 2024 and 2023, 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, 2024 and 2023, 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
September 20, 2024

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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, 2024 and 2023

	2024	2023
CURRENT ASSETS		
Cash and cash equivalents	$ 527,999,319	$ 771,575,961
Investments	1,777,895,941	1,676,736,065
Premiums due from the State of California and CMS	461,899,906	380,839,598
Prepaid expenses and other	103,955,696	108,144,802
Total current assets	2,871,750,862	2,937,296,426
BOARD-DESIGNATED ASSETS AND RESTRICTED CASH		
Cash and cash equivalents	22,817,912	1,940,209
Investments	1,114,945,527	574,611,484
Restricted deposit	300,000	300,000
	1,138,063,439	576,851,693
CAPITAL ASSETS, NET	77,270,145	66,189,127
INTANGIBLE RIGHT-TO-USE SUBSCRIPTION ASSET, net	19,290,669	18,018,382
Total assets	4,106,375,115	3,598,355,628
DEFERRED OUTFLOWS OF RESOURCES		
Net pension	74,549,007	24,373,350
Other postemployment benefit	1,350,000	1,596,000
Total deferred outflows of resources	75,899,007	25,969,350
Total assets and deferred outflows of resources	$ 4,182,274,122	$ 3,624,324,978

See accompanying notes.

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Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health
Statements of Net Position (Continued)
June 30, 2024 and 2023

	2024	2023
CURRENT LIABILITIES		
Medical claims liability and capitation payable		
Medical claims liability	369,433,596	$ 333,993,756
Provider capitation and withholds	176,233,694	125,444,022
Accrued reinsurance costs to providers	7,511,531	4,312,093
Subscription liability	7,134,744	4,556,961
Due to the State of California and CMS	937,276,525	1,303,463,182
Unearned revenue	6,777,509	61,886,332
	1,504,367,599	1,833,656,346
Accounts payable and other	17,667,439	14,540,984
Accrued payroll and employee benefits and other	25,886,668	23,332,392
Total current liabilities	1,547,921,706	1,871,529,722
COMMUNITY REINVESTMENT	106,676,651	-
POSTEMPLOYMENT HEALTH CARE PLAN	17,370,000	18,975,000
SUBSCRIPTION LIABILITY, net of current portion	10,595,755	12,173,318
NET PENSION LIABILITY	45,981,359	40,465,145
Total liabilities	1,728,545,471	1,943,143,185
DEFERRED INFLOWS OF RESOURCES		
Net pension	2,248,445	3,387,516
Other postemployment benefit	6,398,000	7,788,000
Total deferred inflows of resources	8,646,445	11,175,516
NET POSITION		
Net investment in capital assets	78,830,315	67,421,922
Restricted by legislative authority	127,852,909	107,969,096
Unrestricted	2,238,398,982	1,494,615,259
Total net position	2,445,082,206	1,670,006,277
Total liabilities, deferred inflows of resources, and net position	$ 4,182,274,122	$ 3,624,324,978

See accompanying notes.

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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, 2024 and 2023

	2024	2023
REVENUES		
Premium revenues	$ 5,372,963,895	$ 4,239,833,266
Total operating revenues	5,372,963,895	4,239,833,266
OPERATING EXPENSES		
Medical expenses		
Claims expense to providers and facilities	2,094,723,338	1,815,097,808
Provider capitation	1,477,805,330	1,275,685,079
Other medical	528,360,774	367,744,574
OneCare Connect	-	160,125,649
PACE	39,737,377	39,133,937
OneCare	369,285,675	204,408,932
Total medical expenses	4,509,912,494	3,862,195,979
Administrative expenses		
Salaries, wages, and employee benefits	149,096,246	129,037,210
Supplies, occupancy, insurance, and other	39,389,249	31,742,817
Purchased services	22,407,022	15,551,299
Depreciation and amortization	8,008,630	8,114,542
Professional fees	10,609,407	7,892,802
Total administrative expenses	229,510,554	192,338,670
Total operating expenses	4,739,423,048	4,054,534,649
OPERATING INCOME	633,540,847	185,298,617
NON-OPERATING REVENUES		
Net investment income and other	174,598,247	89,740,819
Grant expense	(33,282,237)	(25,530,071)
Rental income, net of related expenses	219,072	987,046
Total non-operating revenues	141,535,082	65,197,794
Increase in net position	775,075,929	250,496,411
NET POSITION, beginning of year	1,670,006,277	1,419,509,866
NET POSITION, end of year	$ 2,445,082,206	$ 1,670,006,277

See accompanying notes.

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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, 2024 and 2023

	2024	2023
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation payments received and other	$ 4,870,608,107	$ 4,607,104,404
Payments to providers and facilities	(4,313,806,893)	(3,896,885,154)
Payments to vendors	(56,642,960)	(62,171,613)
Payments to employees	(195,089,484)	(125,545,812)
Net cash provided by operating activities	305,068,770	522,501,825
CASH FLOWS USED IN CAPITAL AND RELATED FINANCING ACTIVITIES		
Payments on subscription lease obligations	(8,592,862)	(5,414,341)
Purchases of capital assets	(19,216,010)	(6,499,838)
Net cash used in capital and related financing activities	(27,808,872)	(11,914,179)
CASH FLOWS USED IN INVESTING ACTIVITIES		
Investment income received	201,775,923	125,584,618
Purchases of securities	(21,016,264,492)	(46,933,516,529)
Sales of securities	20,326,715,194	46,269,973,906
Payments of grants to providers	(33,282,237)	(25,530,071)
Collections related to rental income	219,072	987,046
Net cash used in investing activities	(520,836,540)	(562,501,030)
Net change in cash and cash equivalents	(243,576,642)	(51,913,384)
CASH AND CASH EQUIVALENTS, beginning of year	771,575,961	823,489,345
CASH AND CASH EQUIVALENTS, end of year	$ 527,999,319	$ 771,575,961
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating income	$ 633,540,847	$ 185,298,617
ADJUSTMENT TO RECONCILE OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Depreciation	15,680,860	10,719,510
Changes in assets and liabilities		
Premiums due from the State of California and CMS	(81,060,308)	24,352,789
Prepaid expenses and other	4,189,106	(13,880,348)
Medical claims liability	35,439,840	32,141,035
Provider capitation and withholds	50,789,672	(67,770,606)
Accrued reinsurance costs to providers	3,199,438	940,396
Due to the State of California and CMS	(366,186,657)	289,081,118
Unearned revenue	(55,108,823)	53,837,231
Accounts payable and other	110,578,033	4,290,685
Accrued payroll and employee benefits and other	2,554,276	3,764,852
Postemployment health care plan	(2,749,000)	(2,207,000)
Net pension liability	(45,798,514)	1,933,546
Net cash provided by operating activities	$ 305,068,770	$ 522,501,825

See accompanying notes.

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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 agency 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 901,300 and 970,600 Medi-Cal beneficiaries for the years ended June 30, 2024 and 2023, 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 17,300 and 17,700 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2024 and 2023, respectively.

In July 2015, CalOptima Health began offering the OneCare Connect Cal Medi Connect Plan, a Medicare-Medicaid Plan, via a contract with CMS and DHCS. OneCare Connect served an average of 14,360 members during the period July 1, 2022 through December 31, 2022 and approximately 14,400 during the year-ended June 30, 2022. The OneCare Connect Program ended on December 31, 2022. Starting January 1, 2023, CalOptima Health transitioned all subscribers from OneCare Connect to the OneCare Plan. Enrollment in the OneCare Connect Program at December 31, 2022 was 14,385.

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 55 years of age or older members 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 Tangible Net Equity (TNE), which CalOptima Health exceeded as of June 30, 2024 and 2023.

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 fiscal 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.

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 May 2024 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 3.0 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

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, premium 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 $27,304,000 and $32,197,000 as of June 30, 2024 and 2023, respectively, and are included in provider capitation and withholds on the statements of net position. During the years ended June 30, 2024 and 2023, CalOptima Health incurred approximately $1,463,590,000 and $1,312,969,000, 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, 2024 and 2023, related to the capitation withhold arrangements, quality incentive payments, and risk-share provisions were approximately $176,234,000 and $125,444,000, 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, 2024 and 2023.

Community reinvestment – CalOptima Health is required to commit a percentage of net position towards 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. As of June 30, 2024, in accordance with State contracts, the balance of the community reinvestment was estimated at approximately $51,400,000 and the balance of the quality achievement was estimated at approximately $55,200,000, for a total estimated accrual of approximately $106,677,000. As the community reinvestment and quality achievement requirement was effective January 1, 2024, no accrual was necessary as of June 30, 2023.

Accrued compensated absences – 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 accrued and recorded in accordance with GASB Codification Section C60 and are included in accrued payroll and employee benefits.

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, including restricted capital assets, net of accumulated depreciation, and is reduced by the outstanding balances of any bonds, notes, or other borrowings that are attributable (if any) 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 law or regulations of other governments. It also pertains to constraints imposed by law or 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 nonoperating 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 nonoperating 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 $966,461,000 and $376,821,000 related to retroactive capitation rate adjustments based on receipt of new information from DHCS during the years ended June 30, 2024 and 2023, respectively.

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.

CalOptima Health was historically subject to DHCS requirements to meet the minimum 85 percent medical loss ratio (MLR) for the Medi-Cal Expansion population per the Affordable Care Act (ACA). On April 5, 2023, CalOptima Health received written confirmation from DHCS that the expansion MLRs for the period of January 1, 2014, through June 30, 2016, were considered closed and final. As a result, CalOptima Health released the expansion MLR liability of approximately $135,390,000 during the year ended June 30, 2023. The amount was recorded within premium revenues on the accompanying statements of revenues, expenses, and changes in net position. In March 2023, CalOptima Health was notified that the Organization was not required to remit any MLR payments to DHCS, nor will DHCS make any additional payment for fiscal year 2018. DHCS has communicated that MCE MLRs are no longer required after June 2018 pending CMS final approval.

Premium revenue and related net receivables as a percent of the totals were as follows as of June 30:

	2024		2023	
	Revenue	%	Revenue	%
Revenue				
Medi-Cal	$ 4,918,009,421	91.5%	$ 3,809,323,101	89.8%
OneCare	407,480,604	7.6%	214,353,873	5.1%
OneCare Connect	-	0.0%	172,148,803	4.1%
PACE	47,473,870	0.9%	44,007,489	1.0%
	$ 5,372,963,895	100.0%	$ 4,239,833,266	100.0%

	2024		2023	
	Receivables	%	Receivables	%
Receivables				
Medi-Cal	$ 438,045,910	94.8%	$ 355,725,299	93.4%
OneCare Connect	19,720,151	4.3%	22,601,354	5.9%
PACE	4,133,845	0.9%	2,512,945	0.7%
	$ 461,899,906	100.0%	$ 380,839,598	100.0%

Effective January 1, 2023, the OneCare Connect program ended and the OneCare Connect enrollment transitioned to the OneCare program. Any residual revenue and expenses related to One Care Connect are recorded as part of the One Care revenue and expenses on the statement of revenues, expenses, and changes in net position.

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 $147,059,000 and $121,159,000 during the years ended June 30, 2024 and 2023, respectively. Under the agreement, approximately $145,317,000 and $119,622,000 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, 2024 and 2023, 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, which 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 $2,918,000 and $5,698,000 as of June 30, 2024 and 2023, respectively, is included in unearned revenues in the statements of net position.

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 four types: (1) Private Hospital Directed Payment Program (PHDP), (2) Public Hospital Enhanced Payment Program (EPP), (3) Public Hospital Quality Incentive Program (QIP), and (4) Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP). Under the Directed Payment program, approximately $314,307,000 and $293,811,000 of the funds that were received from DHCS were passed through to hospitals as requested by DHCS during the years ended June 30, 2024 and 2023, 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 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, 2024 and 2023, the Part D payable balance was approximately $8,808,000 and $1,882,000, 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, 2024 and 2023, the Part D receivable balance was approximately $52,167,000 and $51,860,000, 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.

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, 2024 and 2023, were calculated. CalOptima Health recognized premium tax expense of approximately $657,657,000 and $92,241,000 as a reduction of premium revenues in the statements of revenue, expenses, and changes in net position for the years ended June 30, 2024 and 2023, respectively. As of June 30, 2024, CalOptima Health's MCO tax liability was approximately $153,920,000, and is included in the due to the State of California and CMS line item on the accompanying statements of net position. As the MCO tax expired on December 31, 2022, and was not approved for extension until December 15, 2023, CalOptima Health did not record a MCO tax liability as of June 30, 2023.

Risk corridors – During the year ended June 30, 2021, CalOptima Health's contract with DHCS was subject to a risk corridor for the Managed Long-Term Services and Supports program for the period of July 1, 2015 through June 30, 2017. Additionally, 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 is 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. The State also implemented an Enhanced Care Management (ECM) risk corridor for the period of January 1, 2022 through December 31, 2022, and was extended through December 31, 2024 and Unsatisfactory Immigration Status (UIS) risk corridor for the period of January 2024 to December 2024.

CalOptima Health also participates in the Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) risk corridor for the period of July 1, 2018 through June 30, 2019 and all subsequent years. 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, 2024 and 2023, CalOptima Health recognized a liability of approximately $304,789,000 and $962,366,000, 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, 2024, the increase to premium revenue was approximately $599,501,700 and for year ended June 30, 2023, the reduction of premium revenue was approximately $575,761,000, related to the risk corridors, which is included in premium revenues on the statements of revenues, expenses, and changes in net position.

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 subscription-based information technology arrangements (SBITA). Short term SBITAs, which have a maximum possible term of 12 months or less, 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.

Note 3 – Cash, Cash Equivalents, and Investments

Cash and investments are reported in the statements of net position as follows as of June 30:

	2024	2023
Current assets		
Cash and cash equivalents	$ 527,999,319	$ 771,575,961
Investments	1,777,895,941	1,676,736,065
Board-designated assets and restricted cash		
Cash and cash equivalents	22,817,912	1,940,209
Investments	1,114,945,527	574,611,484
Restricted deposit	300,000	300,000
	$ 3,443,958,699	$ 3,025,163,719

Board-designated assets and restricted cash are available for the following purposes as of June 30:

	2024	2023
Board-designated assets and restricted cash		
Contingency reserve fund	$ 1,137,763,439	$ 576,551,693
Restricted deposit with DMHC	300,000	300,000
	$ 1,138,063,439	$ 576,851,693

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, 2024 and 2023, 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.

Interest rate risk – In accordance with its annual investment policy (investment policy), CalOptima Health manages its exposure to decline 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, 2024 and 2023, CalOptima Health's investments, including cash equivalents, had the following modified duration:

	June 30, 2024			
		Investment Maturities (in Years)		
Investment Type	Fair Value	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	-	-
	3,337,311,446	$ 955,395,590	$ 2,381,915,856	$ -
Accrued interest receivable	22,012,384			
	$ 3,359,323,830			

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	June 30, 2023			
		Investment Maturities (in Years)		
Investment Type	Fair Value	Less Than 1	1–5	More Than 5
U.S. Treasury notes	$ 652,372,690	$ 334,436,427	$ 317,936,263	$ -
U.S. Agency notes	294,565,404	-	294,565,404	-
Corporate bonds	606,478,662	151,600,486	454,878,176	-
Asset-backed securities	167,709,021	41,290,805	126,418,216	-
Mortgage-backed securities	352,525,833	24,026,927	328,498,906	-
Municipal bonds	69,679,079	26,904,673	42,774,406	-
Supranational	9,707,125	-	9,707,125	-
Commercial paper	34,824,599	34,824,599	-	-
Certificates of deposit	48,082,917	48,082,917	-	-
Cash equivalents	666,834,439	666,834,439	-	-
Cash	7,274,284	7,274,284	-	-
	2,910,054,053	$ 1,335,275,557	$ 1,574,778,496	$ -
Accrued interest receivable	15,402,218			
	$ 2,925,456,271			

Investment 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 include 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:

	2024	2023
Asset-backed securities	$ 282,066,505	$ 167,709,021
Mortgage-backed securities	338,957,054	352,525,833
	$ 621,023,559	$ 520,234,854

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 an "A."

As of June 30, 2024, following are the credit ratings of investments and cash equivalents:

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

As of June 30, 2023, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt from Disclosure	Rating as of Year-End					
				AAA	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	$ 709,754,225	N/A	$ 709,754,225	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	472,401,379	N/A	472,401,379	-	-	-	-	-	-
Corporate bonds	610,956,872	A-	-	48,288,393	8,241,443	108,468,276	189,593,093	154,798,256	101,567,411
Asset-backed securities	167,997,222	AA-	-	165,939,194	2,058,028	-	-	-	-
Mortgage-backed securities	355,150,030	AAA	-	355,150,030	-	-	-	-	-
Municipal bonds	107,477,262	A-	-	66,287,078	26,428,815	10,727,556	1,007,344	1,568,179	1,458,290
Supranational	9,779,429	AAA	-	9,779,429	-	-	-	-	-
Certificates of deposit	48,838,522	A1/P1	-	48,838,522	-	-	-	-	-
Commercial paper	435,827,044	A1/P1	-	420,914,269	14,912,775	-	-	-	-
Money market mutual funds	7,274,286	AAA	-	7,274,286	-	-	-	-	-
Total	$ 2,925,456,271		$ 1,182,155,604	$ 1,122,471,201	$ 51,641,061	$ 119,195,832	$ 190,600,437	$ 156,366,435	$ 103,025,701

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 to no more than 5 percent 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 percent may be invested in one money market mutual. As of June 30, 2024 and 2023, 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 transparency 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.

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, 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
	$ 840,085,184	$ 2,030,750,524	$ -	$ 2,870,835,708

	Investment Assets at Fair Value as of June 30, 2023			
	Level 1	Level 2	Level 3	Total
U.S. Treasury notes	$ 652,372,690	$ -	$ -	$ 652,372,690
U.S. Agency notes	-	294,565,404	-	294,565,404
Corporate bonds	-	606,478,662	-	606,478,662
Asset-backed securities	-	167,709,021	-	167,709,021
Mortgage-backed securities	-	352,525,833	-	352,525,833
Municipal bonds	-	69,679,079	-	69,679,079
Supranational	-	9,707,125	-	9,707,125
Commercial paper	-	34,824,599	-	34,824,599
Certificates of deposit	-	48,082,917	-	48,082,917
	$ 652,372,690	$ 1,583,572,640	$ -	$ 2,235,945,330

Note 4 – Capital Assets

Capital assets 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
	14,955,728	$14,705,241	-	(6,159,826)	23,501,143
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
	114,472,422	4,510,769	(770,550)	6,159,826	124,372,467
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
	63,239,023	7,559,702	(195,260)	-	70,603,465
Total depreciable assets, net	51,233,399	(3,048,933)	(575,290)	6,159,826	53,769,002
Capital assets, net	$ 66,189,127	$11,656,308	$ (575,290)	$ -	$ 77,270,145

Capital asset activity during the year ended June 30, 2023, consisted of the following:

	June 30, 2022	Additions	Retirements	Transfers	June 30, 2023
Capital assets not being depreciated					
Land	$ 11,912,499	$ -	$ -	$ -	$ 11,912,499
Construction in progress	3,507,883	6,499,838	-	(6,964,492)	3,043,229
	15,420,382	6,499,838	-	(6,964,492)	14,955,728
Capital assets being depreciated					
Furniture and equipment	8,314,975	-	(81,528)	703,414	8,936,861
Computers and software	39,307,282	-	(7,882,165)	4,930,402	36,355,519
Leasehold improvements	5,059,409	-	(2,400)	239,717	5,296,726
Building	63,092,357	-	(300,000)	1,090,959	63,883,316
	115,774,023	-	(8,266,093)	6,964,492	114,472,422
Less: accumulated depreciation for					
Furniture and equipment	6,909,422	523,445	(81,528)	-	7,351,339
Computers and software	33,589,790	4,070,843	(7,868,331)	-	29,792,302
Leasehold improvements	5,017,129	37,220	(2,400)	-	5,051,949
Building	18,814,022	2,529,411	(300,000)	-	21,043,433
	64,330,363	7,160,919	(8,252,259)	-	63,239,023
Total depreciable assets, net	51,443,660	(7,160,919)	(13,834)	6,964,492	51,233,399
Capital assets, net	$ 66,864,042	$ (661,081)	$ (13,834)	$ -	$ 66,189,127

The Organization recognized depreciation expense of approximately $7,421,000 and $7,053,000 during the years ended June 30, 2024 and 2023, respectively. During the years ended June 30, 2024 and 2023, depreciation expense of approximately $139,000 and $108,000, respectively, was 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:

	2024	2023
Claims payable or pending approval	$ 38,371,849	$ 52,909,889
Provisions for IBNR claims	331,061,747	281,083,867
	$ 369,433,596	$ 333,993,756

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.

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:

	2024	2023
Beginning balance	$ 333,993,756	$ 301,852,721
Incurred		
Current	2,394,253,671	2,099,911,537
Prior	(91,115,588)	(65,796,666)
	2,303,138,083	2,034,114,871
Paid		
Current	2,024,213,932	1,765,917,781
Prior	243,484,311	236,056,055
	2,267,698,243	2,001,973,836
Ending balance	$ 369,433,596	$ 333,993,756

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 $91,116,000 and $65,797,000 for the fiscal years ended June 30, 2024 and 2023, 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.

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, 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, CA 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), a 3-Year Final Compensation Period (Section 20037), Pre-Retirement Death Benefits to Continue After Remarriage of Survivor (Section 21551), as well as 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, 2024, 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
Monthly benefits as a % of eligible compensation	1.092%-2.418%	1.0% to 2.5%
Required employee contribution rates	7.00%	7.75%
Required employer contribution rates	9.17%	9.17%

The following is a summary of plan participants:

	June 30, 2024	June 30, 2023
Active employees	1,599	1,583
Retirees and beneficiaries		
Receiving benefits	255	220
Deferred retirement benefits		
Terminated employees	1,332	1,222
Surviving spouses	5	5
Beneficiaries	2	1

Contributions – Section 20814(c) of the California PERL requires that the employer contribution rates for all public employers are determined on an annual basis by the actuary and shall be 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 is 7.75 percent (Classic and PEPRA New Members) and 7.0 percent (Classic Members) of annual pay for the years ended June 30, 2024 and 2023, respectively. The employer's contribution rate is 9.17 percent and 8.41 percent of annual payroll for the years ended June 30, 2024 and 2023, respectively. On October 3, 2023, CalOptima Health made an additional discretionary payment (ADP) of approximately $50.0 million to reduce the unfunded accrued liability and future required contributions. This ADP is not reflected in CalOptima Health's valuation report for the measurement period ending on June 30, 2023.

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, 2023 (the measurement date), the total pension liability was determined by rolling forward the June 30, 2022 total pension liability. Total pension liabilities were based on the following actuarial methods and assumptions as of June 30, 2023 and June 30, 2022:

Valuation date	June 30, 2022
Measurement date	June 30, 2023
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	7.0% 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

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 are as follows:

	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
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

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2022	$ 240,018,505	$ 239,440,651	$ 577,854
Changes during the year			
Service cost	17,958,280	-	17,958,280
Interest on the total pension liability	17,450,590	-	17,450,590
Changes of benefit terms	-	-	-
Differences between expected and actual experience	(1,930,719)	-	(1,930,719)
Changes of assumptions	8,006,529	-	8,006,529
Contributions from the employer	-	11,688,269	(11,688,269)
Contributions from employees	-	8,634,939	(8,634,939)
Net investment income	-	(18,576,662)	18,576,662
Benefit payments, including refunds of employee contributions	(4,332,714)	(4,332,714)	-
Administrative expenses	-	(149,157)	149,157
Net changes during the year	37,151,966	(2,735,325)	39,887,291
Balance at June 30, 2023	$ 277,170,471	$ 236,705,326	$ 40,465,145

Discount rate and long-term rate of return – The discount rate used to measure the total pension liability was 6.90 percent. 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 plan'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.

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

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 1 percentage point lower or 1 percentage point higher than the current rate:

	June 30, 2024		
	Discount Rate -1% 5.90%	Current Discount Rate 6.90%	Discount Rate +1% 7.90%
Net pension liability	$ 100,402,066	$ 45,981,359	$ 2,195,114

	June 30, 2023		
	Discount Rate -1% 5.90%	Current Discount Rate 6.90%	Discount Rate +1% 7.90%
Net pension liability	$ 88,612,198	$ 40,465,145	$ 1,732,263

Pension expense and deferred outflows/inflows of resources related to pensions – CalOptima Health recognized pension expense of approximately $20,970,000 and $17,255,000 for the years ended June 30, 2024 and 2023, respectively. As of June 30, 2024 and 2023, CalOptima Health recognized deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	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	-
	$ 74,549,007	$ (2,248,445)

	June 30, 2023	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions from employers subsequent to the measurement date	$ 2,375,580	$ -
Net differences between projected and actual earnings on plan investments	12,718,340	-
Changes in assumptions	7,732,138	(1,202,155)
Differences between expected and actual experiences	1,547,292	(2,185,361)
	$ 24,373,350	$ (3,387,516)

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, 2024. 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,	
2024	$ 4,150,398
2025	3,521,390
2026	9,171,760
2027	2,116,544
2028	1,296,914
Thereafter	165,907
	$ 20,422,913

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, 2024 and 2023, 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). All regular and limited-term employees are eligible to participate in the PARS Plan. The current PARS Plan design does not require employee contributions. CalOptima Health makes discretionary employer contributions to the PARS Plan as authorized by the Board of Directors. Vesting occurs over 16 quarters of service. For the years ended June 30, 2024 and 2023, CalOptima Health contributed approximately $6,587,000 and $5,777,000, 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.

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 a 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 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, 2023
Measurement period	July 1, 2022 - June 30, 2023
Valuation date	January 1, 2024

Covered employees – The following numbers of participants were covered by the benefit terms as of June 30:

	2024	2023
Inactives currently receiving benefits	78	76
Active employees	60	65
Inactives entitled to but not yet receiving benefits	2	3
Total	140	144

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 $522,000, including $468,000 in premium payments for retirees and $54,000 for implied subsidies, for the year ended June 30, 2024. CalOptima Health contributed approximately $528,000, which related to implied subsidies, for the year ended June 30, 2023. The most recent actuarial report for the Plan was June 30, 2023. As of that point, the actuarial accrued liability and unfunded actuarial accrued liability for benefits were approximately $17,370,000.

Actuarial assumptions – CalOptima Health's total postemployment retirement liability was measured as of June 30, 2023, and the assumptions used to calculate the total postemployment retirement liability was 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	3.65% at June 30, 2023, Bond Buyer 20 Index 3.54% at June 30, 2022, 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 3.65 percent for June 30, 2023. 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 were as follows:

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

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Balance at June 30, 2022	$ 22,178,000
Changes for the year	
Service cost	668,000
Interest	487,000
Contributions – employer	(529,000)
Assumption changes	(3,829,000)
Net changes	(3,203,000)
Balance at June 30, 2023	$ 18,975,000

Sensitivity of the net OPEB liability to changes in the discount rate – The following presents the net OPEB liability as of June 30, 2024, as well as what the net OPEB liability would be if it were calculated using a discount rate that is 1 percentage point lower or 1 percentage point higher than the current discount rate:

	1% Decrease (2.65%)	Current Rate (3.65%)	1% Increase (4.65%)
Total OPEB liability	$ 19,841,000	$ 17,370,000	$ 15,316,000

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, 2024, as well as what the net OPEB liability would be if it were calculated using health care cost trend rates that are 1 percentage point lower or 1 percentage point higher than the current health care cost trend rates:

	1% Decrease	Current Rate	1% Increase
Total OPEB liability	$ 15,102,000	$ 17,370,000	$ 20,166,000

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For the years ended June 30, 2024 and 2023 CalOptima Health recognized a reduction to OPEB expense of approximately $2,227,000 and $1,679,000, respectively. As of June 30, 2024 and 2023, the reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	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	$ 1,350,000	$ 6,398,000

	June 30, 2023	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ -	$ 2,867,000
Changes in assumptions	1,068,000	4,921,000
Employer contributions made subsequent to measurement date	528,000	-
Total	$ 1,596,000	$ 7,788,000

The $522,000 reported as deferred outflows of resources related to contributions subsequent to the June 30, 2023 measurement date will be recognized as a reduction of the total post-employment retirement liability during the fiscal year ended June 30, 2024.

Other amounts reported as deferred inflows of resources related to OPEB will be recognized as expense as follows:

Years Ending June 30,	
2025	$ (3,573,000)
2026	(1,440,000)
2027	(557,000)
	$ (5,570,000)

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, 2024 and 2023, of $127,852,909 and $107,969,096, respectively. As of June 30, 2024 and 2023, the Organization is in compliance with its TNE requirement.

The Act further required that CalOptima Health maintain a restricted deposit in the amount of $300,000. CalOptima Health met this requirement as of June 30, 2024 and 2023.

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,	
2025	$ 631,929
2026	653,016
2027	710,210
2028	768,055
2029	791,097
Thereafter	1,678,549
	$ 5,232,856

Rental expense under operating leases was approximately $713,000 for the years ended June 30, 2024 and 2023, respectively.

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.

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, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Note 12 –Subscription-based Information Technology Arrangements

CalOptima Health has several subscription contracts that expire at various dates through 2028 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 percent to 8 percent to determine the present value of the subscription liabilities. The amortization on the intangible subscription asset amounted to approximately $7,500,000 and $3,600,000 during the years ended June 30, 2024 and 2023, respectively, and is included in depreciation and amortization on the statement of revenues, expenses and changes in net position. As of June 30, 2024 and 2023, CalOptima Health recognized approximately $19,291,000 and $18,018,000, respectively, in intangible right-to-use subscription assets which is comprised of the intangible right-to-use subscription asset cost of approximately $30,372,000 and $21,733,000, respectively, less accumulated amortization of approximately $11,081,000 and $3,714,000, respectively. As of June 30, 2024 and 2023 CalOptima Health recognized approximately $17,730,000 and $16,730,000, respectively, in SBITA subscription liabilities.

The future subscription payments under SBITA agreements as of June 30, 2024 are as follows:

	Subscriptions		
	Principal	Interest	Total
Years Ending June 30,			
2025	$ 8,125,577	$ 988,688	$ 9,114,265
2026	6,201,136	569,961	6,771,097
2027	4,911,800	196,803	5,108,603
2028	311,281	1,922	313,203
Total undiscounted cash flows	19,549,794	1,757,374	21,307,168
Less: present value discount			3,576,669
Total subscription liabilities			$ 17,730,499

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

	Years Ended June 30,									
	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015
Total pension liability										
Service cost	$ 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	$ 6,464,105
Interest	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	5,661,111
Differences between expected and actual experience	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	(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)	(1,326,364)
Net change in total pension liability	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	10,798,852
Total pension liability – beginning	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	72,912,613
Total pension liability – ending	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	83,711,465
Plan fiduciary net position										
Contributions – employer	$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	3,119,804
Contributions – employee	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	3,385,296
Net investment income	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	12,062,654
Benefit payments, including refunds of employee contributions	(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)	(1,326,364)
Other changes in fiduciary net position	(174,062)	(149,157)	(181,370)	(225,629)	(98,234)	(530,428)	(143,264)	(54,828)	(101,246)	-
Net change in fiduciary net position	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	17,241,390
Plan fiduciary net position – beginning	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	65,410,580
Plan fiduciary net position – ending	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 net pension liability – ending	$ 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	$ 1,059,495
Plan fiduciary net position as percentage of the total liability	85.50%	85.40%	99.76%	85.57%	85.51%	85.40%	82.38%	86.28%	93.23%	98.73%
Covered-employee payroll	$ 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	$ 40,940,556
Plan net pension liability as a percentage of covered-employee payroll	38.11%	36.84%	0.56%	31.22%	29.61%	27.52%	31.29%	22.50%	11.74%	2.59%

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,									
	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015
Actuarially determined contributions	$ 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	$ 3,119,804
Contributions in relation to the actuarially determined contribution	(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)	(3,119,804)
Contribution deficiency (excess)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Covered-employee payroll	$ 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	$ 40,940,556
Contributions as a percentage of covered-employee payroll	11.62%	10.64%	10.34%	9.80%	9.46%	8.85%	6.53%	5.52%	5.45%	7.62%

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

	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	$ 472,000	$ 668,000	$ 1,149,000	$ 811,000	$ 832,000	$ 867,000	$ 1,012,000
Interest	679,000	487,000	718,000	922,000	977,000	900,000	770,000
Benefit changes	-	-	-	-	-	-	-
Actual vs. expected experience	(3,332,000)	-	(6,241,000)	-	(1,072,000)	-	-
Assumption changes	1,104,000	(3,829,000)	(4,514,000)	4,623,000	938,000	(1,067,000)	(2,923,000)
Benefit payments	(528,000)	(529,000)	(544,000)	(570,000)	(556,000)	(560,000)	(572,000)
Net changes	(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)	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)	$ 17,370,000	$ 18,975,000	$ 22,178,000	$ 31,610,000	$ 25,824,000	$ 24,705,000	$ 24,565,000
Total OPEB liability	$ 17,370,000	$ 18,975,000	$ 22,178,000	$ 31,610,000	$ 25,824,000	$ 24,705,000	$ 24,565,000
Covered employee payroll	8,536,000	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	203.5%	214.1%	243.0%	371.3%	309.2%	303.1%	268.9%

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

4. Approve Modifications to Policy GA.3400: Annual Investments

Contact

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

Recommended Action

Approve modifications to the CalOptima Health Policy GA.3400: Annual Investments.

Background

At the February 27, 1996, meeting, the CalOptima Health Board of Directors (Board) approved the Annual Investment Policy (AIP) covering investments made between March 1, 1996, and February 28, 1997. In September 1996, the Board authorized the creation of the Investment Advisory Committee (IAC). The IAC reviews the AIP annually and recommends policy revisions, if necessary, to the Finance and Audit Committee (FAC) and the Board for their respective approvals.

At the December 7, 2023, meeting, the Board approved changes to CalOptima Health Policy GA.3400: Annual Investments for Calendar Year (CY) 2024. The policy was revised to increase opportunities for diversification by adding European Bank for Reconstruction and Development (EBRD) and European Investment Bank (EIB) as eligible investments, changed the maximum percentage investment portfolio for commercial paper from 25% to 30%, and updated language pursuant to California Government Code, Section 53600 *et seq*.

Discussion

Payden & Rygel and MetLife Investment Management, CalOptima Health's investment managers, and Meketa Investment Group, Inc., CalOptima Health's investment adviser, submitted proposed revisions to CalOptima Health Policy GA.3400: Annual Investments for CY 2025. Staff has reviewed the proposed revisions and recommends approval of the modifications listed below.

Below is a list of substantive changes to the policy, which are reflected in the attached redline. The list does not include non-substantive changes that may also be reflected in the redline (*i.e.*, formatting, spelling, punctuation, capitalization, minor clarifying language, and/or grammatical changes).

Policy Section	Proposed Change	Rationale	Impact
III.D.2.i.i.a)	Remove "Which are rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services: and" and	Updates language to better define the ratings.	None.

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Policy Section	Proposed Change	Rationale	Impact
	add "Which have attained the highest ranking, or the highest letter and numerical rating provided by not less than two (2) of the three (3) nationally recognized rating services (AAAm by Standard & Poor's, Aaa-mf – Moody's Investors Service, and AAA/mmf – Fitch Ratings)."		
III.D.2.k.iv.	Add "Are not issued or guaranteed by Federal Agencies and U.S. Government Sponsored Agencies" to the section regarding Mortgage or Asset-backed Securities.	Clarifies that the limitations outlined in Government Code Section 53601(o) for Mortgage or Asset-backed Securities do not apply to investments under Sections 53601(b) for U.S. Treasuries and 53601(f) for Federal Agencies and U.S. Government Sponsored Enterprises.	None.
III.D.2.m.i.	Remove European Bank for Reconstruction and Development (EBRD); and European Investment Bank (EIB) from list of Supranatural Institutions that are eligible for investments.	Removes these institutions as eligible investments, as investment managers investing on behalf of local agencies cannot make investments in these entities directly.	None.
Throughout	Revise references to include the Statutory Reserve Fund.	Updates references to conform with revisions made to CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds.	None.

Fiscal Impact
There is no immediate fiscal impact.

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Rationale for Recommendation

The proposed changes to CalOptima Health Policy GA.3400: Annual Investments reflect the recommendations of CalOptima Health's investment managers, Payden & Rygel and MetLife Investment Management, with concurrence from CalOptima Health's investment adviser, Meketa Investment Group, Inc. These recommended changes continue to support CalOptima Health's goals to maintain safety of principal and achieve a market rate of return while maintaining necessary liquidity during periods of uncertainty. Per the review conducted by Meketa Investment Group, Inc., there were no changes in the California Government Code affecting local agencies noted for CY 2025.

Concurrence

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

Attachments

1. Policy GA.3400: Annual Investment Policy – redline and clean versions

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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Policy:	GA.3400
Title:	**Annual Investments**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2018
Revised Date:	01/01/2025
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy sets forth the investment guidelines for all Operating Funds, Statutory and Board-Designated Reserve Funds of CalOptima Health invested on or after January 10, 2006, to ensure CalOptima Health's funds are prudently invested according to the Board of Directors objectives and the California Government Code to preserve Capital, provide necessary Liquidity, and achieve a market-average Rate of Return through Economic Cycles. Each annual review takes effect upon its adoption by the Board of Directors.

II. POLICY

A. CalOptima Health investments may only be made as authorized by this Policy.

1. This Policy shall conform to California Government Code, Section 53600 et seq. (hereinafter, the Code) as well as customary standards of prudent investment management. Should the provisions of the Code be, or become, more restrictive than those contained herein, such provisions shall be considered immediately incorporated into this Policy and adhered to.

2. Safety of Principal: Safety of Principal is the primary objective of CalOptima Health and, as such, each investment transaction shall seek to ensure that large Capital losses are avoided from securities or Broker-Dealer default.

   a. CalOptima Health shall seek to ensure that Capital losses are minimized from the erosion of market value and preserve principal by mitigating the two (2) types of Risk: Credit Risk and Market Risk.

      i. Credit Risk shall be mitigated by investing in only permitted investments and by diversifying the Investment Portfolio, in accordance with this Policy.

      ii. Market Risk shall be mitigated by matching Maturity Dates, to the extent possible, with CalOptima Health's expected cash flow needs and other factors.

   b. It is explicitly recognized herein, however, that in a diversified portfolio, occasional losses are inevitable and must be considered within the context of the overall investment return.

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3. Liquidity: Liquidity is the second most important objective of CalOptima Health. It is important that each portfolio contain investments for which there is a secondary market, and which offer the flexibility to be easily sold at any time with minimal Risk of loss of either the principal or interest based upon then prevailing rates.

4. Total Return: CalOptima Health's Investment Portfolios shall be designed to attain a market-average Rate of Return through Economic Cycles given an acceptable level of Risk, established by the Board of Directors' and the CalOptima Health Treasurer's objectives.

   a. The performance Benchmark for each Investment Portfolio shall be based upon published Market Indices as primary Benchmark, and Custom Peer Group Reports, as necessary, for short-term investments of comparable Risk and duration.

      i. These performance Benchmarks shall be reviewed monthly by CalOptima Health staff, and quarterly by CalOptima Health's Treasurer and the Investment Advisory Committee members and shall be reported to the Board of Directors.

B. The investments purchased by an Investment Manager shall be held by the Custodian Bank acting as the agent of CalOptima Health under the terms of a custody agreement in compliance with California Government Code, Section 53608.

C. Investment Managers must certify that they will purchase securities from Broker-Dealers (other than themselves) or financial institutions in compliance with California Government Code, Section 53601.5 and this Policy.

D. The Board of Directors, or persons authorized to make investment decisions on behalf of CalOptima Health (e.g., Chief Officers), are trustees and fiduciaries subject to the Prudent Person Standard, as defined in the Code, which shall be applied in the context of managing an overall portfolio.

E. CalOptima Health's Officers, employees, Board members, and Investment Advisory Committee members involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to fulfill their roles in the investment process.

   1. CalOptima Health's Officers and employees involved in the investment process are not permitted to have any material financial interests in financial institutions, including state or federal credit unions, that conduct business with CalOptima Health, and are not permitted to have any personal financial, or investment holdings, that could be materially related to the performance of CalOptima Health's investments.

F. On an annual basis, CalOptima Health's Treasurer shall provide the Board of Directors with this Policy for review and adoption by the Board, to ensure that all investments made follow this Policy.

   1. This Policy shall be reviewed annually by the Board of Directors at a public meeting pursuant to California Government Code, Section 53646, Subdivision (a).

   2. This policy may only be changed by the Board of Directors.

III. PROCEDURE

A. Delegation of Authority

1. The Authority to manage CalOptima Health's investment program is derived from an order of the Board of Directors.

    a. Management responsibility for the investment program shall be delegated to CalOptima Health's Treasurer, as appointed by the Board of Directors, for a one (1)-year period following the approval of this Policy.

        i. The Board of Directors may renew the delegation of authority annually.

    b. No person may engage in investment transactions except as provided under the terms of this Policy and the procedures established by CalOptima Health's Treasurer.

B. CalOptima Health Treasurer Responsibilities

1. The Treasurer shall be responsible for:

    a. All actions undertaken and shall establish a system of controls to regulate the activities of subordinate officials and Board-approved Investment Managers;

    b. The oversight of CalOptima Health's Investment Portfolio;

    c. Directing CalOptima Health's investment program and for compliance with this Policy pursuant to the delegation of authority to invest funds or to sell or exchange securities; and

    d. Providing a quarterly report to the Board of Directors in accordance with California Government Code, Section 53646, Subdivision (b).

2. The Treasurer shall also be responsible for ensuring that:

    a. The Operating Funds, Statutory and Board-Designated Reserve Funds targeted average maturities are established and reviewed monthly.

    b. All Investment Managers are provided a copy of this Policy, which shall be appended to an Investment Manager's investment contract.

        i. Any investments made by an Investment Manager outside this Policy may subject the Investment Manager to termination for cause or other appropriate remedies or sanctions, as determined by the Board of Directors.

    c. Investment diversification and portfolio performance is reviewed monthly to ensure that Risk levels and returns are reasonable and that investments are diversified in accordance with this Policy.

    d. All Investment Managers are selected and evaluated for review by the Chief Executive Officer and the Board of Directors.

C. Investment Advisory Committee

1. The Investment Advisory Committee shall not make, or direct, CalOptima Health staff to make any particular investment, purchase any particular investment product, or conduct business with any particular investment companies, or brokers.

a. It shall not be the purpose of the Investment Advisory Committee to advise on particular investment decisions of CalOptima Health.

2. The Investment Advisory Committee shall be responsible for the following functions:

a. Annual review of this Policy before its consideration by the Board of Directors and revision recommendations, as necessary, to the Finance and Audit Committee of the Board of Directors.

b. Quarterly review of CalOptima Health's Investment Portfolio for conformance with this Policy's diversification and maturity guidelines, and recommendations to the Finance and Audit Committee of the Board of Directors, as appropriate.

c. Provision of comments to CalOptima Health's staff regarding potential investments and potential investment strategies.

d. Performance of such additional duties and responsibilities pertaining to CalOptima Health's investment program as may be required from time to time by specific action and direction of the Board of Directors.

D. Permitted Investments

1. CalOptima Health shall invest only in Instruments as permitted by the Code, subject to the limitations of this Policy.

a. Permitted investments under the Operating Funds, unless otherwise specified, are subject to a maximum stated term of three (3) years. Note that the Code allows for up to five (5) years.

b. Permitted investments under the Statutory and Board-Designated Reserve Funds, unless otherwise specified, are subject to a maximum stated term of five (5) years. Note that the Code allows for up to five (5) years.

c. The Board of Directors must grant express written authority to make an investment, or to establish an investment program, of a longer term.

2. Permitted investments shall include:

a. U.S. Treasuries

i. These investments are direct obligations of the United States of America and securities which are fully and unconditionally guaranteed as to the timely payment of principal and interest by the full faith and credit of the United States of America.

ii. U.S. Government securities include:

a) Treasury Bills: U.S. Government securities issued and traded at a discount;

b) Treasury Notes and Bonds: Interest bearing debt obligations of the U.S. Government which guarantees interest and principal payments;

c) Treasury Separate Trading of Registered Interest and Principal Securities (STRIPS): U.S. Treasury securities that have been separated into their component parts of principal and interest payments and recorded as such in the Federal Reserve book-entry record-keeping system;

d) Treasury Inflation Protected (TIPs) securities: Special U.S. Treasury notes, or Bonds, that offer protection from Inflation. Coupon payments and underlying principal are automatically increased to compensate for Inflation, as measured by the Consumer Price Index (CPI); and

e) Treasury Floating Rate Notes (FRNs): U.S. Treasury Bonds issued with a variable coupon.

iii. U.S. Treasury coupon and principal STRIPS, as well as TIPs, are not considered to be derivatives for the purposes of this Policy and are, therefore, permitted investments pursuant to this Policy.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

b. Federal Agencies and U.S. Government Sponsored Enterprises

i. These investments represent obligations, participations, or other Instruments of, or issued by, a federal agency or a U.S. government sponsored enterprise, including those issued by, or fully guaranteed as to principal and interest by, the issuers.

ii. These are U.S. Government related organizations, the largest of which are government financial intermediaries assisting specific credit markets (e.g., housing, agriculture). Often simply referred to as "Agencies," the following are specifically allowed:

a) Federal Home Loan Banks (FHLB);

b) Federal Home Loan Mortgage Corporation (FHLMC);

c) Federal National Mortgage Association (FNMA);

d) Federal Farm Credit Banks (FFCB);

e) Government National Mortgage Association (GNMA);

f) Small Business Administration (SBA);

g) Export-Import Bank of the United States;

h) U.S. Maritime Administration;

i) Washington Metro Area Transit Authority (WMATA);

j) U.S. Department of Housing & Urban Development;

k) Tennessee Valley Authority;

l) Federal Agricultural Mortgage Company (FAMC);

m) Federal Deposit Insurance Corporation (FDIC)-backed Structured Sale Guaranteed Notes (SSGNs); and

n) National Credit Union Administration (NCUA) securities.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

iv. Any Federal Agency and U.S. Government Sponsored Enterprise security not specifically mentioned above is not a permitted investment.

c. State and California Local Agency Obligations

i. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's, or A-1 by Standard & Poor's, or Rated F1 by Fitch, or equivalent or better for short-term obligations, or an "A-" rating or its equivalent or better by a Nationally Recognized Statistical Rating Organization (NRSRO) for long-term obligations. Public agency Bonds issued for private purposes (e.g., industrial development Bonds) are specifically excluded as permitted investments.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

d. Banker's Acceptances

i. Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the Banker's Acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances:

a) Are eligible for purchase by the Federal Reserve System and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by

Moody's, or are comparably rated by a ~~nationally recognized rating agency.~~NRSRO.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	180 days	180 days
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 180 days 180 days	 180 days 180 days

e. Commercial Paper (CP)

i. CP is negotiable (i.e., marketable or transferable), although it is typically held to maturity. ~~-~~The maximum maturity is two hundred seventy (270) days, with most CP issued for terms of less than thirty (30) days. CP must meet the following criteria:

a) CP of "prime" quality, rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term by Moody's, or are comparably rated by a ~~nationally recognized statistical rating organization (NRSRO);~~NRSRO;

b) The entity that issues the CP shall meet all of the following conditions in either paragraph (1) or (2):

(1) The entity meets the following criteria:

(A) Is organized and operating in the United States as a general corporation.

(B) Has total assets in excess of five hundred million dollars ($500,000,000).

(C) Has debt other than commercial paper, if any, that is rated in a Rating Category of "A" or its equivalent or higher by ~~an~~a NRSRO.

(2) The entity meets the following criteria:

(A) Is organized within the United States as a special purpose corporation, trust, or limited liability company.

(B) Has program wide credit enhancements including, but not limited to, overcollateralization, letters of credit, or a surety bond.

(C) Has commercial paper that is rated "A-1" or higher, or the equivalent, by ~~an~~a NRSRO; and

c) May not represent more than ten percent (10%) of the outstanding CP of the issuing corporation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	270 days	270 days
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 270 days 270 days	 270 days 270 days

f. Negotiable Certificates of Deposit

i. Negotiable Certificates of Deposit must be issued by a Nationally- or state-chartered bank, or state or federal association or by a state licensed branch of a foreign bank, which have been rated F1 or better, by Fitch Ratings Service, or are rated A-1 for short-term deposits by Standard & Poor's and P-1 for short-term deposits by Moody's or are comparably rated by a ~~nationally recognized rating agency~~NRSRO.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	1 year	5 years
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 1 year 1 year	 5 years 5 years

g. Repurchase Agreements

i. U.S. Treasury and U.S. Agency Repurchase Agreements collateralized by the U.S. Government may be purchased through any registered primary Broker-Dealer subject to the Securities Investors Protection Act, or any commercial bank insured by the Federal Deposit Insurance Corporation so long as at the time of the investment, such primary dealer (or its parent) has an uninsured, unsecured, and unguaranteed obligation rated P-1 short-term, or A-2 long-term, or better, by Moody's, and A-1 short-term, or A long-term, or better, by Standard & Poor's, and F1 short-term, or A long-term or better by Fitch Ratings Service provided:

a) A Broker-Dealer master repurchase agreement signed by the Investment Manager (acting as "Agent") and approved by CalOptima Health;

b) The securities are held free and clear of any Lien by CalOptima Health's custodian or an independent third party acting as agent ("Agent") for the custodian, and such third party is (i) a Federal Reserve Bank, or (ii) a bank which is a member of the Federal Deposit Insurance Corporation and which has combined Capital, Surplus and undivided profits of not less than fifty million dollars ($50,000,000) and the custodian receives written confirmation from such third party that it holds such securities, free and clear of any Lien, as agent for CalOptima Health's custodian;

c) A perfected first security interest under the Uniform Commercial Code, or book entry procedures prescribed at Title 31, Code of Federal Regulations, Section 306.1 et seq., and such securities are created for the benefit of CalOptima Health's custodian and CalOptima Health; and

d) The Agent will notify CalOptima Health's custodian and CalOptima Health if the Valuation of the Collateral Securities falls outside of policy. Upon direction by the CalOptima Health Treasurer, the Agent will liquidate the Collateral Securities if any deficiency in the required one hundred and two percent (102%) collateral percentage is not restored within one (1) business day of such Valuation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	30 days	1 year
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 30 days 30 days	 1 year 1 year

iii. Reverse Repurchase Agreements are not allowed.

h. Corporate Securities

i. For the purpose of this Policy, permissible Corporate Securities shall be rated in a Rating Category of "A" or its equivalent or better by ~~an~~a NRSRO and:

a) Be issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state and operating within the U.S. and have total assets in excess of five hundred million dollars ($500,000,000), and

b) May not represent more than ten percent (10%) of the issue in the case of a specific public offering. ~~-~~This limitation does not apply to debt that is "continuously offered" in a mode similar to CP, i.e., Medium Term Notes (MTNs).

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

i. Money Market Funds

i. Shares of beneficial interest issued by diversified management companies (i.e., money market funds):

a) Which ~~are rated AAA (or equivalent~~ have attained the highest ranking~~)~~ or the highest letter and numerical rating provided by not less than two (2) of the three (3) ~~largest nationally recognized rating services; and~~NRSROs (AAAm by Standard & Poor's, Aaa-mf – Moody's Investors Service, and AAA/mmf – Fitch Ratings); and

b) Such investment may not represent more than ten percent (10%) of the money market fund's assets.

j. Joint Powers Authority Pool

i. A joint powers authority formed pursuant to California Government Code; Section 6509.7 may issue shares of beneficial interest to participating public agencies. The joint powers authority issuing the shares shall have retained an Investment Advisor that meets all of the following criteria:

a) Registered or exempt from registration with the Securities and Exchange Commission;

b) No less than five (5) years of experience investing in the securities and obligations authorized in the Code; and

c) Assets under management in excess of five hundred million dollars ($500,000,000).

ii. A Joint Powers Authority Pool shall be rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest ~~nationally recognized rating services~~NRSROs.

iii. Such an investment may not represent more than ten percent (10%) of the Joint Powers Authority Pool's assets.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	Not Applicable	Not Applicable
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	Not Applicable Not Applicable	Not Applicable Not Applicable

k. Mortgage or Asset-backed Securities

i. Pass-through securities are Instruments by which the cash flow from the mortgages, receivables, or other assets underlying the security, is passed-through as principal and interest payments to the investor.

ii. Though these securities may contain a third-party guarantee, they are a package of assets being sold by a trust, not a debt obligation of the sponsor. ~~-~~Other types of "backed" debt Instruments have assets (e.g., leases or consumer receivables) pledged to support the debt service.

iii. Any mortgage pass-through security, collateralized mortgage obligations, mortgage-backed or other pay-through bond, equipment lease-backed certificate, consumer receivable pass-through certificate, or consumer receivable-backed bond which:

a) Are rated AA or its equivalent or better by ~~an~~a NRSRO.

iv. Are not issued or guaranteed by Federal Agencies and U.S. Government Sponsored Agencies.

~~iv.~~v. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

l. Variable and Floating Rate Securities

i. Variable and floating rate securities are appropriate investments when used to enhance yield and reduce Risk.

a) They should have the same stability, Liquidity, and quality as comparable fixed rate securities.

b) A variable rate security provides for the automatic establishment of a new interest rate on pre-determined reset dates.

c) For the purposes of this Policy, a variable rate security and floating rate security shall be deemed to have a maturity equal to the period remaining to that pre-determined interest rate reset date, so long as no investment shall be made in a security that at the time of the investment has a term remaining to a stated final maturity in excess of five (5) years.

ii. Variable and floating rate securities, which are restricted to investments in permitted Federal Agencies and U.S. Government Sponsored Enterprises securities, Corporate Securities, Mortgage or Asset-backed Securities, Negotiable Certificates of Deposit, and Municipal Bonds (State and California Local Agency Obligations) must utilize a single, market-determined short-term index rate, such as U. S. Treasury bills, federal funds, CP, London Interbank Offered Rate (LIBOR), the Secured Overnight Financing Rate (SOFR), or Securities Industry and Financial Markets Association (SIFMA) that is pre-determined at the time of issuance of the security.

a) Permitted variable and floating rate securities that have an embedded unconditional put option must have a stated final maturity of the security no greater than five (5) years.

b) Investments in floating rate securities whose reset is calculated using more than one (1) of the above indices are not permitted, i.e., dual index notes.

c) Ratings for variable and floating rate securities shall be limited to the same minimum ratings as applied to the appropriate asset security class outlined elsewhere in this Policy.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

m. Supranational Obligations

i. The ~~five (5~~three (3) Supranational Institutions that issue, or unconditionally guarantee, obligations that are eligible investments are:

a) International Bank for Reconstruction and Development (IBRD);

b) International Finance Corporation (IFC);

c) Inter-American Development Bank (IADB);

~~d) European Bank for Reconstruction and Development (EBRD); and~~

~~e) European Investment Bank (EIB).~~

ii. Supranational obligations shall be rated in a Rating Category of "AA" or its equivalent or better by a ~~Nationally Statistical Rating Organization (NRSRO).~~ NRSRO.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

n. Pooled Investments

i. Pooled investments include deposits, or investments pooled with those of other local agencies consistent with the requirements of California Government Code, Section 53635 et seq. Such pools may contain a variety of investments but are limited to those permissible under the Code.

E. Diversification Guidelines

1. Diversification guidelines ensure the portfolio is not unduly concentrated in the securities of one (1) type, industry, or entity, thereby assuring adequate portfolio Liquidity should one (1) sector or company experience difficulties.

2. CalOptima Health's Investment Managers must review the respective portfolios they manage to ensure compliance with CalOptima Health's diversification guidelines on a continuous basis.

3. *Table 1: Maximum Percentage (%) of Investment Portfolio, by Instrument Type*

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
A. U.S. Treasuries (including U.S. Treasury Coupon and principal STRIPS as well as TIPs)	100% (Code)
B. Federal Agencies and U.S. Government Sponsored Enterprises	100% (Code)
C. State and California Local Agency Obligations	40% (Code 100%)

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
D. Bankers Acceptances	30% (Code 40%)
E. Commercial Paper	30% (Code 40%[1])
F. Negotiable Certificates of Deposit	30% (Code)
G. Repurchase Agreements	100% (Code)
H. Corporate Securities	30% (Code)
I. Money Market Funds	20% (Code)
J. Joint Powers Authority Pool	100% (Code)
K. Mortgage or Asset-backed Securities	20% (Code)
L. Variable and Floating Rate Securities	30% (Code)
M. Supranational Obligations	30% (Code)

4. Issuer or Counterparty Diversification Guidelines: The percentages specified below shall be adhered to on the basis of the entire portfolio:

   a. Any one (1) Federal Agency or Government Sponsored Enterprise: None

   b. Any one (1) repurchase agreement counterparty name:

      If maturity/term is ≤ 7 days: 50%
      If maturity/term is > 7 days: 25%

5. Issuer or Counterparty Diversification Guidelines for all other permitted investments described in Section III.D.2.a-n. of this Policy.

   a. Any one (1) corporation, bank, local agency, or other corporate name for one (1) or more series of securities, and specifically with respect to special purpose vehicles issuers for mortgage or asset-backed securities, the maximum issuer limits apply at the deal level with each securitized trust being considered a unique "issuer."

   b. Except for U.S. Government or Agency securities, no more than five percent (5%) of the Portfolio's market value will be invested in securities of a single issuer.

6. Each Investment Manager shall adhere to the diversification limits discussed in this subsection.

   a. If an Investment Manager exceeds the aforementioned diversification limits, the Investment Manager shall inform CalOptima Health's Treasurer and Investment Advisory consultant (if any) by close of business on the day of the occurrence.

   b. Within the parameters authorized by the Code, the Investment Advisory Committee recognizes the practicalities of portfolio management, securities maturing and changing status, and market volatility, and, as such, will consider breaches in the context of.

      i. The amount in relation to the total portfolio concentration;

      ii. Market and security specific conditions contributing to a breach of this Policy; and

[1] The Code allows up to 40% for Pooled Funds and Non-Pooled Funds with a minimum $100,000,000 of investments. The Maximum Allocation is limited to 25% for Non-Pooled Funds with under $100,000,000 of investments.

iii. The Investment Managers' actions to enforce the spirit of this Policy and decisions made in the best interest of the portfolio.

F. Maximum Stated Term

1. Maximum stated terms for permitted investments shall be determined based on the settlement date (not the trade date) upon purchase of the security and the stated final maturity of the security. Any forward settlement that exceeds 45 days from the time of investment is prohibited.

G. Rating Downgrades

1. CalOptima Health may from time to time be invested in a security whose rating is downgraded below the quality criteria permitted by this Policy.

2. If the rating of any security held as an investment falls below the investment guidelines, the Investment Manager shall notify CalOptima Health's Treasurer, or Designee, within two (2) business days of the downgrade.

a. A decision to retain a downgraded security shall be approved by CalOptima Health's Treasurer, or Designee, within five (5) business days of the downgrade.

H. Investment Restrictions

1. Investment securities shall not be lent to an Investment Manager, or Broker-Dealer.

2. The Investment Portfolio or Investment Portfolios, managed by an Investment Manager, shall not be used as collateral to obtain additional investable funds.

3. Any investment not specifically referred to herein shall be considered a prohibited investment.

4. CalOptima Health reserves the right to prohibit its Investment Managers from making investments in organizations which have a line of business that conflicts with the interests of public health, as determined by the Board of Directors.

5. CalOptima Health reserves the right to prohibit investments in organizations with which it has a business relationship through contracting, purchasing, or other arrangements.

6. Except as expressly permitted by this Policy, investments in derivative securities shall not be allowed.

7. A list of prohibited investments does not currently exist, however, the Board of Directors shall provide CalOptima Health's Treasurer, Investment Managers, Investment Advisory consultant, and Investment Advisory Committee with a list, should such a list be adopted by CalOptima Health in the future, of organizations that do not comply with this Policy and shall immediately notify CalOptima Health's Treasurer, Investment Managers, Investment Advisory consultant and Investment Advisory Committee of any changes.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Government Code, §53600 et seq.
B. California Government Code, §53601(h), (k), (q)
C. California Government Code, §53635 et seq.
D. California Government Code. §53646, Subdivision (a) and Subdivision (b)
E. California Government Code, §6509.7
F. California Government Code, §16430(m)
G. Title 31, Code of Federal Regulations (C.F.R.), §306.1 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/30/2017	Special Meeting of the CalOptima Investment Advisory Committee
11/16/2017	Regular Meeting of the CalOptima Finance and Audit Committee
12/07/2017	Regular Meeting of the CalOptima Board of Directors
11/05/2018	Special Meeting of the CalOptima Investment Advisory Committee
11/15/2018	Regular Meeting of the CalOptima Finance and Audit Committee
12/06/2018	Regular Meeting of the CalOptima Board of Directors
10/21/2019	Regular Meeting of the CalOptima Investment Advisory Committee
11/15/2019	Regular Meeting of the CalOptima Finance and Audit Committee
12/05/2019	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
10/19/2020	Regular Meeting of the CalOptima Investment Advisory Committee
11/19/2020	Regular Meeting of the CalOptima Finance and Audit Committee
12/03/2020	Regular Meeting of the CalOptima Board of Directors
10/25/2021	Regular Meeting of the CalOptima Investment Advisory Committee
11/18/2021	Regular Meeting of the CalOptima Finance and Audit Committee
12/20/2021	Special Meeting of the CalOptima Board of Directors
10/24/2022	Regular Meeting of the CalOptima Health Investment Advisory Committee
11/17/2022	Regular Meeting of the CalOptima Health Finance and Audit Committee
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
10/23/2023	Regular Meeting of the CalOptima Health Investment Advisory Committee
11/16/2023	Regular Meeting of the CalOptima Health Finance and Audit Committee
12/07/2023	Regular Meeting of the CalOptima Health Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2018	GA.3400	Annual Investments	Administrative
Revised	01/01/2019	GA.3400	Annual Investments	Administrative
Revised	01/01/2020	GA.3400	Annual Investments	Administrative

Action	Date	Policy	Policy Title	Program(s)
Revised	06/04/2020	GA.3400	Annual Investments	Administrative
Revised	01/01/2021	GA.3400	Annual Investments	Administrative
Revised	01/01/2022	GA.3400	Annual Investments	Administrative
Revised	01/01/2023	GA.3400	Annual Investments	Administrative
Revised	01/01/2024	GA.3400	Annual Investments	Administrative
Revised	01/01/2025	GA.3400	Annual Investments	Administrative

IX. GLOSSARY

Term	Definition
Banker's Acceptance (BA)	Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the banker's acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances: 1. Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency; and 2. May not exceed the five percent (5%) limit of any one (1) commercial bank and may not exceed the five percent (5%) limit for any security of any bank.
Benchmark	Benchmarks are usually constructed using unmanaged indices, exchange-traded Funds or mutual fund categories to represent each asset class. Benchmarks are often used as a tool to assess the allocation, Risk and return of a portfolio.
~~Board-Designated Reserve Funds~~	~~Funds established to address unexpected agency needs and not intended for use in the normal course of business. The amount of Board-Designated Reserve Funds should be offset by any working Capital or net current asset deficits. The desired level for these funds is a minimum of 1.4 and maximum of 2.0 months of capitation revenues as specified by CalOptima Health Policy GA.3001: Board-Designated Reserve Funds. The Board-Designated Reserve Funds shall be managed and invested as follows:~~ ~~1. Tier One~~ ~~a. Used for the benefit and protection of CalOptima Health's long-term financial viability;~~ ~~b. Used to cover "Special Purposes" as defined in CalOptima Health Policy GA.3001: Board-Designated Reserve Funds; or~~ ~~c. May be used for operational cash flow needs in lieu of a bank line of credit in the event of disruption of monthly capitation revenue receipts from the State, subject to the Board-Designated Reserve Funds having a "floor" equal to Tier Two requirements.~~ ~~2. Tier Two~~ ~~a. Used to meet CalOptima Health's regulatory compliance requirements; or~~ ~~b. Currently defined as CalOptima Health's tangible net equity requirements as defined by Subdivision (e) of Section 1300.76 of Title 28 of the California Code of Regulations.~~
Bonds	A debt security, under which the issuer owes the holders a debt and, depending on the terms of the bond, is obliged to pay them interest (the coupon) and/or to repay the principal at a later date, termed the maturity date.

Term	Definition
Broker-Dealer	In financial services, a Broker-Dealer is a natural person, a company or other organization that engages in the business of trading securities for its own account or on behalf of its customers.
CalOptima Health Treasurer	Appointed by CalOptima Health's Board of Directors, the treasurer is a person responsible for overseeing CalOptima Health's investment funds.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Cash Flow Draws	Amount of cash needs to support CalOptima Health business operation.
Chief Officers	For the purposes of this policy, may include, but is not limited to, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and/or Chief Counsel.
Collateral Securities	A security given in addition to the direct security, and subordinate to it, intended to guarantee its validity or convertibility or insure its performance; so that, if the direct security fails, the creditor may fall back upon the collateral security.
Commercial Paper (CP)	Unsecured promissory notes issued by companies and government entities at a discount.
Consumer Price Index (CPI)	The Consumer Price Indexes (CPI) program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services.
Corporate Securities	Notes issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state, and operating within the U.S.
Credit Risk	The Risk of loss due to failure of the issuer of a security.
Custodian Bank	A specialized financial institution responsible for safeguarding a firm's or individual's financial assets and is not engaged in "traditional" commercial or consumer/retail banking such as mortgage or personal lending, branch banking, personal accounts, automated teller machines (ATMs) and so forth.
Custom Peer Group Report	Developed based on a small peer universe with similar investment guidelines. The Purpose of the report is to provide more accurate performance comparison.
Designee	For purposes of this policy, a person who has been designated to act on behalf of the CalOptima Health Treasurer.
Economic Cycles	The natural fluctuation of the economy between periods of expansion (growth) and contraction (recession).
Finance and Audit Committee (FAC)	A standing committee of the CalOptima Health Board of Directors with oversight responsibilities for all financial matters of CalOptima Health including but not limited to: budget development and approval, financial reporting, investment practices and policies, purchasing and procurement practices and policies, insurance issues, and capitation and claims. The Committee serves as the primary level of Board review for any finance-related issues or policies affecting the CalOptima Health program.
Inflation	Inflation is the rate at which the general level of prices for goods and services is rising and, consequently, the purchasing power of currency is falling.
Instrument	Refers to a financial Instrument or asset that can be traded.- These assets can be cash, Bonds, or shares in a company
Investment Advisor(s)	Registered or non-registered person or group that makes investment recommendations or conducts securities analysis in return for a fee.

Term	Definition
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Health Board of Directors who provide advice and recommendations regarding CalOptima Health's Investment Policies, Procedures and Practices.
Investment Manager(s)	A person or organization that makes investments in portfolios of securities on behalf of clients, in accordance with the investment objectives and parameters defined by these clients.
Investment Portfolio	A grouping of financial assets such as stocks, Bonds and cash equivalents, as well as their funds counterparts, including mutual, exchange-traded and closed funds. Portfolios are held directly by investors and/or managed by financial professionals.
Joint Powers Authority Pool	Shares of beneficial interest issued by a joint powers authority organized pursuant to California Government Code, Section 6509.7; each share represents an equal proportional interest in the Underlying Pool of Securities owned by the joint powers authority.
Lien	A legal right granted by the owner of property, by a law or otherwise acquired by a creditor
Liquidity	Liquidity describes the degree to which an asset or security can be quickly bought or sold in the market without affecting the asset's price.
Market Indices	Measurements of the value of a section of the stock market. It is computed from the prices of selected stocks (typically a weighted average).
Market Risk	The Risk of market value fluctuations due to overall changes in the general level of interest rates.
Maturity Dates	The date on which the principal amount of a note, draft, acceptance bond or another debt Instrument becomes due and is repaid to the investor and interest payments stop. It is also the termination or due date on which an installment loan must be paid in full.
Medium Term Notes (MTN)	A debt note that usually matures (is paid back) in five (5) – ten (10) years, but the term may be less than one (1) year or as long as one hundred (100) years. They can be issued on a fixed or floating coupon basis.
Nationally Recognized Statistical Ratings Organization (NRSRO)	A credit rating agency that the Securities and Exchange Commission in the United States registers and uses for regulatory purposes. -Current NRSROs listed at www.sec.gov/ocr/ocr-current-nrsros.html.
Negotiable Certificates of Deposit	A negotiable (i.e., marketable or transferable) receipt for a time deposit at a bank or other financial institution, for a fixed time and interest rate.
Operating Funds	Funds intended to serve as a money market account for CalOptima Health to meet daily operating requirements. -Deposits to this fund are comprised of State warrants that represent CalOptima Health's monthly capitation revenues from its State contracts. -Disbursements from this fund to CalOptima Health's operating cash accounts are intended to meet operating expenses, payments to providers and other payments required in day-to-day operations.
Prudent Person Standard	When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of the agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the Liquidity needs of the agency (California Government Code, Section 53600.3)

Term	Definition
Rate of Return	The gain or loss on an investment over a specified time period, expressed as a percentage of the investment's cost. Gains on investments are defined as income received plus any Capital gains realized on the sale of the investment.
Rating Category	With respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.
Repurchase Agreements	A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.
Risk	Investment Risk can be defined as the probability or likelihood of occurrence of losses relative to the expected return on any particular investment. Description: Stating simply, it is a measure of the level of uncertainty of achieving the returns as per the expectations of the investor.
State and California Local Agency Obligations	Registered warrants, notes or Bonds of any of the fifty (50) U.S. states, including Bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the fifty (50) U.S. states. Additionally, Bonds, notes, warrants, or other evidences of indebtedness of any local agency within the State of California, including Bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency, or by a department, board, agency or authority of the State or local agency.
Statutory and Board-Designated Reserve Funds	Funds established to address unexpected agency needs and not intended for use in the normal course of business. The Statutory and Board-Designated Reserve Funds should be offset by any working Capital or net current asset deficits. The desired level for the Board Designated reserve funds is a minimum of 2.5 and maximum of 3.0 months of capitation revenues and a Statutory reserve between 100% and 110% of Tangible Net Equity (TNE) as specified by CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds. CalOptima Health shall utilize the Tier 1 investment portfolio for the Board-designated Reserve and Tier 2 for Statutory Reserve.
Supranational Institutions	International institutions formed by two (2) or more governments that transcend boundaries to pursue mutually beneficial economic or social goals.
Surplus	Assets beyond liabilities.
Underlying Pool of Securities	Those securities and obligations that are eligible for direct investment by local public agencies.
Valuation	An estimation of the worth of a financial Instrument or asset. CalOptima Health's asset managers provide CalOptima Health with reporting that shows the Valuation of each financial Instrument that they own on behalf of CalOptima Health. Each asset manager uses a variety of market sources to determine individual Valuations.

1

Policy:	GA.3400
Title:	**Annual Investments**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2018
Revised Date:	01/01/2025
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy sets forth the investment guidelines for all Operating Funds, Statutory and Board-Designated Reserve Funds of CalOptima Health invested on or after January 10, 2006, to ensure CalOptima Health's funds are prudently invested according to the Board of Directors objectives and the California Government Code to preserve Capital, provide necessary Liquidity, and achieve a market-average Rate of Return through Economic Cycles. Each annual review takes effect upon its adoption by the Board of Directors.

II. POLICY

A. CalOptima Health investments may only be made as authorized by this Policy.

1. This Policy shall conform to California Government Code, Section 53600 et seq. (hereinafter, the Code) as well as customary standards of prudent investment management. Should the provisions of the Code be, or become, more restrictive than those contained herein, such provisions shall be considered immediately incorporated into this Policy and adhered to.

2. Safety of Principal: Safety of Principal is the primary objective of CalOptima Health and, as such, each investment transaction shall seek to ensure that large Capital losses are avoided from securities or Broker-Dealer default.

   a. CalOptima Health shall seek to ensure that Capital losses are minimized from the erosion of market value and preserve principal by mitigating the two (2) types of Risk: Credit Risk and Market Risk.

      i. Credit Risk shall be mitigated by investing in only permitted investments and by diversifying the Investment Portfolio, in accordance with this Policy.

      ii. Market Risk shall be mitigated by matching Maturity Dates, to the extent possible, with CalOptima Health's expected cash flow needs and other factors.

   b. It is explicitly recognized herein, however, that in a diversified portfolio, occasional losses are inevitable and must be considered within the context of the overall investment return.

3. Liquidity: Liquidity is the second most important objective of CalOptima Health. It is important that each portfolio contain investments for which there is a secondary market, and which offer

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the flexibility to be easily sold at any time with minimal Risk of loss of either the principal or interest based upon then prevailing rates.

4. Total Return: CalOptima Health's Investment Portfolios shall be designed to attain a market-average Rate of Return through Economic Cycles given an acceptable level of Risk, established by the Board of Directors' and the CalOptima Health Treasurer's objectives.

   a. The performance Benchmark for each Investment Portfolio shall be based upon published Market Indices as primary Benchmark, and Custom Peer Group Reports, as necessary, for short-term investments of comparable Risk and duration.

      i. These performance Benchmarks shall be reviewed monthly by CalOptima Health staff, and quarterly by CalOptima Health's Treasurer and the Investment Advisory Committee members and shall be reported to the Board of Directors.

B. The investments purchased by an Investment Manager shall be held by the Custodian Bank acting as the agent of CalOptima Health under the terms of a custody agreement in compliance with California Government Code, Section 53608.

C. Investment Managers must certify that they will purchase securities from Broker-Dealers (other than themselves) or financial institutions in compliance with California Government Code, Section 53601.5 and this Policy.

D. The Board of Directors, or persons authorized to make investment decisions on behalf of CalOptima Health (e.g., Chief Officers), are trustees and fiduciaries subject to the Prudent Person Standard, as defined in the Code, which shall be applied in the context of managing an overall portfolio.

E. CalOptima Health's Officers, employees, Board members, and Investment Advisory Committee members involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to fulfill their roles in the investment process.

   1. CalOptima Health's Officers and employees involved in the investment process are not permitted to have any material financial interests in financial institutions, including state or federal credit unions, that conduct business with CalOptima Health, and are not permitted to have any personal financial, or investment holdings, that could be materially related to the performance of CalOptima Health's investments.

F. On an annual basis, CalOptima Health's Treasurer shall provide the Board of Directors with this Policy for review and adoption by the Board, to ensure that all investments made follow this Policy.

   1. This Policy shall be reviewed annually by the Board of Directors at a public meeting pursuant to California Government Code, Section 53646, Subdivision (a).

   2. This policy may only be changed by the Board of Directors.

III. PROCEDURE

A. Delegation of Authority

   1. The Authority to manage CalOptima Health's investment program is derived from an order of the Board of Directors.

a. Management responsibility for the investment program shall be delegated to CalOptima Health's Treasurer, as appointed by the Board of Directors, for a one (1)-year period following the approval of this Policy.

i. The Board of Directors may renew the delegation of authority annually.

b. No person may engage in investment transactions except as provided under the terms of this Policy and the procedures established by CalOptima Health's Treasurer.

B. CalOptima Health Treasurer Responsibilities

1. The Treasurer shall be responsible for:

a. All actions undertaken and shall establish a system of controls to regulate the activities of subordinate officials and Board-approved Investment Managers;

b. The oversight of CalOptima Health's Investment Portfolio;

c. Directing CalOptima Health's investment program and for compliance with this Policy pursuant to the delegation of authority to invest funds or to sell or exchange securities; and

d. Providing a quarterly report to the Board of Directors in accordance with California Government Code, Section 53646, Subdivision (b).

2. The Treasurer shall also be responsible for ensuring that:

a. The Operating Funds, Statutory and Board-Designated Reserve Funds targeted average maturities are established and reviewed monthly.

b. All Investment Managers are provided a copy of this Policy, which shall be appended to an Investment Manager's investment contract.

i. Any investments made by an Investment Manager outside this Policy may subject the Investment Manager to termination for cause or other appropriate remedies or sanctions, as determined by the Board of Directors.

c. Investment diversification and portfolio performance is reviewed monthly to ensure that Risk levels and returns are reasonable and that investments are diversified in accordance with this Policy.

d. All Investment Managers are selected and evaluated for review by the Chief Executive Officer and the Board of Directors.

C. Investment Advisory Committee

1. The Investment Advisory Committee shall not make, or direct, CalOptima Health staff to make any particular investment, purchase any particular investment product, or conduct business with any particular investment companies, or brokers.

a. It shall not be the purpose of the Investment Advisory Committee to advise on particular investment decisions of CalOptima Health.

2. The Investment Advisory Committee shall be responsible for the following functions:

a. Annual review of this Policy before its consideration by the Board of Directors and revision recommendations, as necessary, to the Finance and Audit Committee of the Board of Directors.

b. Quarterly review of CalOptima Health's Investment Portfolio for conformance with this Policy's diversification and maturity guidelines, and recommendations to the Finance and Audit Committee of the Board of Directors, as appropriate.

c. Provision of comments to CalOptima Health's staff regarding potential investments and potential investment strategies.

d. Performance of such additional duties and responsibilities pertaining to CalOptima Health's investment program as may be required from time to time by specific action and direction of the Board of Directors.

D. Permitted Investments

1. CalOptima Health shall invest only in Instruments as permitted by the Code, subject to the limitations of this Policy.

a. Permitted investments under the Operating Funds, unless otherwise specified, are subject to a maximum stated term of three (3) years. Note that the Code allows for up to five (5) years.

b. Permitted investments under the Statutory and Board-Designated Reserve Funds, unless otherwise specified, are subject to a maximum stated term of five (5) years. Note that the Code allows for up to five (5) years.

c. The Board of Directors must grant express written authority to make an investment, or to establish an investment program, of a longer term.

2. Permitted investments shall include:

a. U.S. Treasuries

i. These investments are direct obligations of the United States of America and securities which are fully and unconditionally guaranteed as to the timely payment of principal and interest by the full faith and credit of the United States of America.

ii. U.S. Government securities include:

a) Treasury Bills: U.S. Government securities issued and traded at a discount;

b) Treasury Notes and Bonds: Interest bearing debt obligations of the U.S. Government which guarantees interest and principal payments;

c) Treasury Separate Trading of Registered Interest and Principal Securities (STRIPS): U.S. Treasury securities that have been separated into their component parts of principal and interest payments and recorded as such in the Federal Reserve book-entry record-keeping system;

d) Treasury Inflation Protected (TIPs) securities: Special U.S. Treasury notes, or Bonds, that offer protection from Inflation. Coupon payments and underlying

principal are automatically increased to compensate for Inflation, as measured by the Consumer Price Index (CPI); and

e) Treasury Floating Rate Notes (FRNs): U.S. Treasury Bonds issued with a variable coupon.

iii. U.S. Treasury coupon and principal STRIPS, as well as TIPs, are not considered to be derivatives for the purposes of this Policy and are, therefore, permitted investments pursuant to this Policy.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

b. Federal Agencies and U.S. Government Sponsored Enterprises

i. These investments represent obligations, participations, or other Instruments of, or issued by, a federal agency or a U.S. government sponsored enterprise, including those issued by, or fully guaranteed as to principal and interest by, the issuers.

ii. These are U.S. Government related organizations, the largest of which are government financial intermediaries assisting specific credit markets (e.g., housing, agriculture). Often simply referred to as "Agencies," the following are specifically allowed:

a) Federal Home Loan Banks (FHLB);

b) Federal Home Loan Mortgage Corporation (FHLMC);

c) Federal National Mortgage Association (FNMA);

d) Federal Farm Credit Banks (FFCB);

e) Government National Mortgage Association (GNMA);

f) Small Business Administration (SBA);

g) Export-Import Bank of the United States;

h) U.S. Maritime Administration;

i) Washington Metro Area Transit Authority (WMATA);

j) U.S. Department of Housing & Urban Development;

k) Tennessee Valley Authority;

l) Federal Agricultural Mortgage Company (FAMC);

m) Federal Deposit Insurance Corporation (FDIC)-backed Structured Sale Guaranteed Notes (SSGNs); and

n) National Credit Union Administration (NCUA) securities.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

iv. Any Federal Agency and U.S. Government Sponsored Enterprise security not specifically mentioned above is not a permitted investment.

c. State and California Local Agency Obligations

i. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's, or A-1 by Standard & Poor's, or Rated F1 by Fitch, or equivalent or better for short-term obligations, or an "A-" rating or its equivalent or better by a Nationally Recognized Statistical Rating Organization (NRSRO) for long-term obligations. Public agency Bonds issued for private purposes (e.g., industrial development Bonds) are specifically excluded as permitted investments.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

d. Banker's Acceptances

i. Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the Banker's Acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances:

a) Are eligible for purchase by the Federal Reserve System and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a NRSRO.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	180 days	180 days

Fund Type	Term Assigned	Term Allowed by the Code
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 180 days 180 days	 180 days 180 days

e. Commercial Paper (CP)

i. CP is negotiable (i.e., marketable or transferable), although it is typically held to maturity. The maximum maturity is two hundred seventy (270) days, with most CP issued for terms of less than thirty (30) days. CP must meet the following criteria:

a) CP of "prime" quality, rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term by Moody's, or are comparably rated by a NRSRO;

b) The entity that issues the CP shall meet all of the following conditions in either paragraph (1) or (2):

(1) The entity meets the following criteria:

(A) Is organized and operating in the United States as a general corporation.

(B) Has total assets in excess of five hundred million dollars ($500,000,000).

(C) Has debt other than commercial paper, if any, that is rated in a Rating Category of "A" or its equivalent or higher by a NRSRO.

(2) The entity meets the following criteria:

(A) Is organized within the United States as a special purpose corporation, trust, or limited liability company.

(B) Has program wide credit enhancements including, but not limited to, overcollateralization, letters of credit, or a surety bond.

(C) Has commercial paper that is rated "A-1" or higher, or the equivalent, by a NRSRO; and

c) May not represent more than ten percent (10%) of the outstanding CP of the issuing corporation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	270 days	270 days
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 270 days 270 days	 270 days 270 days

f. Negotiable Certificates of Deposit

i. Negotiable Certificates of Deposit must be issued by a Nationally- or state-chartered bank, or state or federal association or by a state licensed branch of a foreign bank, which have been rated F1 or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's and P-1 for short-term deposits by Moody's or are comparably rated by a NRSRO.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	1 year	5 years
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 1 year 1 year	 5 years 5 years

g. Repurchase Agreements

i. U.S. Treasury and U.S. Agency Repurchase Agreements collateralized by the U.S. Government may be purchased through any registered primary Broker-Dealer subject to the Securities Investors Protection Act, or any commercial bank insured by the Federal Deposit Insurance Corporation so long as at the time of the investment, such primary dealer (or its parent) has an uninsured, unsecured, and unguaranteed obligation rated P-1 short-term, or A-2 long-term, or better, by Moody's, and A-1 short-term, or A long-term, or better, by Standard & Poor's, and F1 short-term, or A long-term or better by Fitch Ratings Service provided:

a) A Broker-Dealer master repurchase agreement signed by the Investment Manager (acting as "Agent") and approved by CalOptima Health;

b) The securities are held free and clear of any Lien by CalOptima Health's custodian or an independent third party acting as agent ("Agent") for the custodian, and such third party is (i) a Federal Reserve Bank, or (ii) a bank which is a member of the Federal Deposit Insurance Corporation and which has combined Capital, Surplus and undivided profits of not less than fifty million dollars ($50,000,000) and the custodian receives written confirmation from such third party that it holds such securities, free and clear of any Lien, as agent for CalOptima Health's custodian;

c) A perfected first security interest under the Uniform Commercial Code, or book entry procedures prescribed at Title 31, Code of Federal Regulations, Section 306.1 et seq., and such securities are created for the benefit of CalOptima Health's custodian and CalOptima Health; and

d) The Agent will notify CalOptima Health's custodian and CalOptima Health if the Valuation of the Collateral Securities falls outside of policy. Upon direction by the CalOptima Health Treasurer, the Agent will liquidate the Collateral Securities if any deficiency in the required one hundred and two percent (102%) collateral percentage is not restored within one (1) business day of such Valuation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	30 days	1 year

Fund Type	Term Assigned	Term Allowed by the Code
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 30 days 30 days	 1 year 1 year

iii. Reverse Repurchase Agreements are not allowed.

h. Corporate Securities

i. For the purpose of this Policy, permissible Corporate Securities shall be rated in a Rating Category of "A" or its equivalent or better by a NRSRO and:

a) Be issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state and operating within the U.S. and have total assets in excess of five hundred million dollars ($500,000,000), and

b) May not represent more than ten percent (10%) of the issue in the case of a specific public offering. This limitation does not apply to debt that is "continuously offered" in a mode similar to CP, i.e., Medium Term Notes (MTNs).

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

i. Money Market Funds

i. Shares of beneficial interest issued by diversified management companies (i.e., money market funds):

a) Which have attained the highest ranking or the highest letter and numerical rating provided by not less than two (2) of the three (3) NRSROs (AAAm by Standard & Poor's, Aaa-mf – Moody's Investors Service, and AAA/mmf – Fitch Ratings); and

b) Such investment may not represent more than ten percent (10%) of the money market fund's assets.

j. Joint Powers Authority Pool

i. A joint powers authority formed pursuant to California Government Code; Section 6509.7 may issue shares of beneficial interest to participating public agencies. The joint powers authority issuing the shares shall have retained an Investment Advisor that meets all of the following criteria:

a) Registered or exempt from registration with the Securities and Exchange Commission;

b) No less than five (5) years of experience investing in the securities and obligations authorized in the Code; and

c) Assets under management in excess of five hundred million dollars ($500,000,000).

ii. A Joint Powers Authority Pool shall be rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest NRSROs.

iii. Such an investment may not represent more than ten percent (10%) of the Joint Powers Authority Pool's assets.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	Not Applicable	Not Applicable
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 Not Applicable Not Applicable	 Not Applicable Not Applicable

k. Mortgage or Asset-backed Securities

i. Pass-through securities are Instruments by which the cash flow from the mortgages, receivables, or other assets underlying the security, is passed-through as principal and interest payments to the investor.

ii. Though these securities may contain a third-party guarantee, they are a package of assets being sold by a trust, not a debt obligation of the sponsor. Other types of "backed" debt Instruments have assets (e.g., leases or consumer receivables) pledged to support the debt service.

iii. Any mortgage pass-through security, collateralized mortgage obligations, mortgage-backed or other pay-through bond, equipment lease-backed certificate, consumer receivable pass-through certificate, or consumer receivable-backed bond which:

a) Are rated AA or its equivalent or better by a NRSRO.

iv. Are not issued or guaranteed by Federal Agencies and U.S. Government Sponsored Agencies.

v. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

l. Variable and Floating Rate Securities

i. Variable and floating rate securities are appropriate investments when used to enhance yield and reduce Risk.

a) They should have the same stability, Liquidity, and quality as comparable fixed rate securities.

b) A variable rate security provides for the automatic establishment of a new interest rate on pre-determined reset dates.

c) For the purposes of this Policy, a variable rate security and floating rate security shall be deemed to have a maturity equal to the period remaining to that pre-determined interest rate reset date, so long as no investment shall be made in a security that at the time of the investment has a term remaining to a stated final maturity in excess of five (5) years.

ii. Variable and floating rate securities, which are restricted to investments in permitted Federal Agencies and U.S. Government Sponsored Enterprises securities, Corporate Securities, Mortgage or Asset-backed Securities, Negotiable Certificates of Deposit, and Municipal Bonds (State and California Local Agency Obligations) must utilize a single, market-determined short-term index rate, such as U. S. Treasury bills, federal funds, CP, London Interbank Offered Rate (LIBOR), the Secured Overnight Financing Rate (SOFR), or Securities Industry and Financial Markets Association (SIFMA) that is pre-determined at the time of issuance of the security.

a) Permitted variable and floating rate securities that have an embedded unconditional put option must have a stated final maturity of the security no greater than five (5) years.

b) Investments in floating rate securities whose reset is calculated using more than one (1) of the above indices are not permitted, i.e., dual index notes.

c) Ratings for variable and floating rate securities shall be limited to the same minimum ratings as applied to the appropriate asset security class outlined elsewhere in this Policy.

iii. Maximum Term:

Fund Type	**Term Assigned**	**Term Allowed by the Code**
Operating Funds	3 years	5 years
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

m. Supranational Obligations

i. The three (3) Supranational Institutions that issue, or unconditionally guarantee, obligations that are eligible investments are:

a) International Bank for Reconstruction and Development (IBRD);

b) International Finance Corporation (IFC);

c) Inter-American Development Bank (IADB);

ii. Supranational obligations shall be rated in a Rating Category of "AA" or its equivalent or better by a NRSRO.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Statutory and Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

n. Pooled Investments

i. Pooled investments include deposits, or investments pooled with those of other local agencies consistent with the requirements of California Government Code, Section 53635 et seq. Such pools may contain a variety of investments but are limited to those permissible under the Code.

E. Diversification Guidelines

1. Diversification guidelines ensure the portfolio is not unduly concentrated in the securities of one (1) type, industry, or entity, thereby assuring adequate portfolio Liquidity should one (1) sector or company experience difficulties.

2. CalOptima Health's Investment Managers must review the respective portfolios they manage to ensure compliance with CalOptima Health's diversification guidelines on a continuous basis.

3. *Table 1: Maximum Percentage (%) of Investment Portfolio, by Instrument Type*

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
A. U.S. Treasuries (including U.S. Treasury Coupon and principal STRIPS as well as TIPs)	100% (Code)
B. Federal Agencies and U.S. Government Sponsored Enterprises	100% (Code)
C. State and California Local Agency Obligations	40% (Code 100%)
D. Bankers Acceptances	30% (Code 40%)
E. Commercial Paper	30% (Code 40%[1])
F. Negotiable Certificates of Deposit	30% (Code)
G. Repurchase Agreements	100% (Code)
H. Corporate Securities	30% (Code)
I. Money Market Funds	20% (Code)
J. Joint Powers Authority Pool	100% (Code)
K. Mortgage or Asset-backed Securities	20% (Code)
L. Variable and Floating Rate Securities	30% (Code)
M. Supranational Obligations	30% (Code)

[1] The Code allows up to 40% for Pooled Funds and Non-Pooled Funds with a minimum $100,000,000 of investments. The Maximum Allocation is limited to 25% for Non-Pooled Funds with under $100,000,000 of investments.

4. Issuer or Counterparty Diversification Guidelines: The percentages specified below shall be adhered to on the basis of the entire portfolio:

    a. Any one (1) Federal Agency or Government Sponsored Enterprise: None

    b. Any one (1) repurchase agreement counterparty name:

        If maturity/term is ≤ 7 days: 50%
        If maturity/term is > 7 days: 25%

5. Issuer or Counterparty Diversification Guidelines for all other permitted investments described in Section III.D.2.a-n. of this Policy.

    a. Any one (1) corporation, bank, local agency, or other corporate name for one (1) or more series of securities, and specifically with respect to special purpose vehicles issuers for mortgage or asset-backed securities, the maximum issuer limits apply at the deal level with each securitized trust being considered a unique "issuer."

    b. Except for U.S. Government or Agency securities, no more than five percent (5%) of the Portfolio's market value will be invested in securities of a single issuer.

6. Each Investment Manager shall adhere to the diversification limits discussed in this subsection.

    a. If an Investment Manager exceeds the aforementioned diversification limits, the Investment Manager shall inform CalOptima Health's Treasurer and Investment Advisory consultant (if any) by close of business on the day of the occurrence.

    b. Within the parameters authorized by the Code, the Investment Advisory Committee recognizes the practicalities of portfolio management, securities maturing and changing status, and market volatility, and, as such, will consider breaches in the context of.

        i. The amount in relation to the total portfolio concentration;

        ii. Market and security specific conditions contributing to a breach of this Policy; and

        iii. The Investment Managers' actions to enforce the spirit of this Policy and decisions made in the best interest of the portfolio.

F. Maximum Stated Term

1. Maximum stated terms for permitted investments shall be determined based on the settlement date (not the trade date) upon purchase of the security and the stated final maturity of the security. Any forward settlement that exceeds 45 days from the time of investment is prohibited.

G. Rating Downgrades

1. CalOptima Health may from time to time be invested in a security whose rating is downgraded below the quality criteria permitted by this Policy.

2. If the rating of any security held as an investment falls below the investment guidelines, the Investment Manager shall notify CalOptima Health's Treasurer, or Designee, within two (2) business days of the downgrade.

a. A decision to retain a downgraded security shall be approved by CalOptima Health's Treasurer, or Designee, within five (5) business days of the downgrade.

H. Investment Restrictions

1. Investment securities shall not be lent to an Investment Manager, or Broker-Dealer.

2. The Investment Portfolio or Investment Portfolios, managed by an Investment Manager, shall not be used as collateral to obtain additional investable funds.

3. Any investment not specifically referred to herein shall be considered a prohibited investment.

4. CalOptima Health reserves the right to prohibit its Investment Managers from making investments in organizations which have a line of business that conflicts with the interests of public health, as determined by the Board of Directors.

5. CalOptima Health reserves the right to prohibit investments in organizations with which it has a business relationship through contracting, purchasing, or other arrangements.

6. Except as expressly permitted by this Policy, investments in derivative securities shall not be allowed.

7. A list of prohibited investments does not currently exist, however, the Board of Directors shall provide CalOptima Health's Treasurer, Investment Managers, Investment Advisory consultant, and Investment Advisory Committee with a list, should such a list be adopted by CalOptima Health in the future, of organizations that do not comply with this Policy and shall immediately notify CalOptima Health's Treasurer, Investment Managers, Investment Advisory consultant and Investment Advisory Committee of any changes.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Government Code, §53600 et seq.
B. California Government Code, §53601(h), (k), (q)
C. California Government Code, §53635 et seq.
D. California Government Code. §53646, Subdivision (a) and Subdivision (b)
E. California Government Code, §6509.7
F. California Government Code, §16430(m)
G. Title 31, Code of Federal Regulations (C.F.R.), §306.1 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/30/2017	Special Meeting of the CalOptima Investment Advisory Committee
11/16/2017	Regular Meeting of the CalOptima Finance and Audit Committee

Date	Meeting
12/07/2017	Regular Meeting of the CalOptima Board of Directors
11/05/2018	Special Meeting of the CalOptima Investment Advisory Committee
11/15/2018	Regular Meeting of the CalOptima Finance and Audit Committee
12/06/2018	Regular Meeting of the CalOptima Board of Directors
10/21/2019	Regular Meeting of the CalOptima Investment Advisory Committee
11/15/2019	Regular Meeting of the CalOptima Finance and Audit Committee
12/05/2019	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
10/19/2020	Regular Meeting of the CalOptima Investment Advisory Committee
11/19/2020	Regular Meeting of the CalOptima Finance and Audit Committee
12/03/2020	Regular Meeting of the CalOptima Board of Directors
10/25/2021	Regular Meeting of the CalOptima Investment Advisory Committee
11/18/2021	Regular Meeting of the CalOptima Finance and Audit Committee
12/20/2021	Special Meeting of the CalOptima Board of Directors
10/24/2022	Regular Meeting of the CalOptima Health Investment Advisory Committee
11/17/2022	Regular Meeting of the CalOptima Health Finance and Audit Committee
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
10/23/2023	Regular Meeting of the CalOptima Health Investment Advisory Committee
11/16/2023	Regular Meeting of the CalOptima Health Finance and Audit Committee
12/07/2023	Regular Meeting of the CalOptima Health Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2018	GA.3400	Annual Investments	Administrative
Revised	01/01/2019	GA.3400	Annual Investments	Administrative
Revised	01/01/2020	GA.3400	Annual Investments	Administrative
Revised	06/04/2020	GA.3400	Annual Investments	Administrative
Revised	01/01/2021	GA.3400	Annual Investments	Administrative
Revised	01/01/2022	GA.3400	Annual Investments	Administrative
Revised	01/01/2023	GA.3400	Annual Investments	Administrative
Revised	01/01/2024	GA.3400	Annual Investments	Administrative
Revised	01/01/2025	GA.3400	Annual Investments	Administrative

IX. GLOSSARY

Term	Definition
Banker's Acceptance (BA)	Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the banker's acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances: 1. Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency; and 2. May not exceed the five percent (5%) limit of any one (1) commercial bank and may not exceed the five percent (5%) limit for any security of any bank.
Benchmark	Benchmarks are usually constructed using unmanaged indices, exchange-traded Funds or mutual fund categories to represent each asset class. Benchmarks are often used as a tool to assess the allocation, Risk and return of a portfolio.
Bonds	A debt security, under which the issuer owes the holders a debt and, depending on the terms of the bond, is obliged to pay them interest (the coupon) and/or to repay the principal at a later date, termed the maturity date.
Broker-Dealer	In financial services, a Broker-Dealer is a natural person, a company or other organization that engages in the business of trading securities for its own account or on behalf of its customers.
CalOptima Health Treasurer	Appointed by CalOptima Health's Board of Directors, the treasurer is a person responsible for overseeing CalOptima Health's investment funds.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Cash Flow Draws	Amount of cash needs to support CalOptima Health business operation.
Chief Officers	For the purposes of this policy, may include, but is not limited to, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and/or Chief Counsel.
Collateral Securities	A security given in addition to the direct security, and subordinate to it, intended to guarantee its validity or convertibility or insure its performance; so that, if the direct security fails, the creditor may fall back upon the collateral security.
Commercial Paper (CP)	Unsecured promissory notes issued by companies and government entities at a discount.
Consumer Price Index (CPI)	The Consumer Price Indexes (CPI) program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services.
Corporate Securities	Notes issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state, and operating within the U.S.
Credit Risk	The Risk of loss due to failure of the issuer of a security.

Term	Definition
Custodian Bank	A specialized financial institution responsible for safeguarding a firm's or individual's financial assets and is not engaged in "traditional" commercial or consumer/retail banking such as mortgage or personal lending, branch banking, personal accounts, automated teller machines (ATMs) and so forth.
Custom Peer Group Report	Developed based on a small peer universe with similar investment guidelines. The Purpose of the report is to provide more accurate performance comparison.
Designee	For purposes of this policy, a person who has been designated to act on behalf of the CalOptima Health Treasurer.
Economic Cycles	The natural fluctuation of the economy between periods of expansion (growth) and contraction (recession).
Finance and Audit Committee (FAC)	A standing committee of the CalOptima Health Board of Directors with oversight responsibilities for all financial matters of CalOptima Health including but not limited to: budget development and approval, financial reporting, investment practices and policies, purchasing and procurement practices and policies, insurance issues, and capitation and claims. The Committee serves as the primary level of Board review for any finance-related issues or policies affecting the CalOptima Health program.
Inflation	Inflation is the rate at which the general level of prices for goods and services is rising and, consequently, the purchasing power of currency is falling.
Instrument	Refers to a financial Instrument or asset that can be traded. These assets can be cash, Bonds, or shares in a company
Investment Advisor(s)	Registered or non-registered person or group that makes investment recommendations or conducts securities analysis in return for a fee.
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Health Board of Directors who provide advice and recommendations regarding CalOptima Health's Investment Policies, Procedures and Practices.
Investment Manager(s)	A person or organization that makes investments in portfolios of securities on behalf of clients, in accordance with the investment objectives and parameters defined by these clients.
Investment Portfolio	A grouping of financial assets such as stocks, Bonds and cash equivalents, as well as their funds counterparts, including mutual, exchange-traded and closed funds. Portfolios are held directly by investors and/or managed by financial professionals.
Joint Powers Authority Pool	Shares of beneficial interest issued by a joint powers authority organized pursuant to California Government Code, Section 6509.7; each share represents an equal proportional interest in the Underlying Pool of Securities owned by the joint powers authority.
Lien	A legal right granted by the owner of property, by a law or otherwise acquired by a creditor
Liquidity	Liquidity describes the degree to which an asset or security can be quickly bought or sold in the market without affecting the asset's price.
Market Indices	Measurements of the value of a section of the stock market. It is computed from the prices of selected stocks (typically a weighted average).
Market Risk	The Risk of market value fluctuations due to overall changes in the general level of interest rates.
Maturity Dates	The date on which the principal amount of a note, draft, acceptance bond or another debt Instrument becomes due and is repaid to the investor and interest payments stop. It is also the termination or due date on which an installment loan must be paid in full.

Term	Definition
Medium Term Notes (MTN)	A debt note that usually matures (is paid back) in five (5) – ten (10) years, but the term may be less than one (1) year or as long as one hundred (100) years. They can be issued on a fixed or floating coupon basis.
Nationally Recognized Statistical Ratings Organization (NRSRO)	A credit rating agency that the Securities and Exchange Commission in the United States registers and uses for regulatory purposes. Current NRSROs listed at www.sec.gov/ocr/ocr-current-nrsros.html.
Negotiable Certificates of Deposit	A negotiable (i.e., marketable or transferable) receipt for a time deposit at a bank or other financial institution, for a fixed time and interest rate.
Operating Funds	Funds intended to serve as a money market account for CalOptima Health to meet daily operating requirements. Deposits to this fund are comprised of State warrants that represent CalOptima Health's monthly capitation revenues from its State contracts. Disbursements from this fund to CalOptima Health's operating cash accounts are intended to meet operating expenses, payments to providers and other payments required in day-to-day operations.
Prudent Person Standard	When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of the agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the Liquidity needs of the agency (California Government Code, Section 53600.3)
Rate of Return	The gain or loss on an investment over a specified time period, expressed as a percentage of the investment's cost. Gains on investments are defined as income received plus any Capital gains realized on the sale of the investment.
Rating Category	With respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.
Repurchase Agreements	A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.
Risk	Investment Risk can be defined as the probability or likelihood of occurrence of losses relative to the expected return on any particular investment. Description: Stating simply, it is a measure of the level of uncertainty of achieving the returns as per the expectations of the investor.
State and California Local Agency Obligations	Registered warrants, notes or Bonds of any of the fifty (50) U.S. states, including Bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the fifty (50) U.S. states. Additionally, Bonds, notes, warrants, or other evidences of indebtedness of any local agency within the State of California, including Bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency, or by a department, board, agency or authority of the State or local agency.

Term	Definition
Statutory and Board-Designated Reserve Funds	Funds established to address unexpected agency needs and not intended for use in the normal course of business. The Statutory and Board-Designated Reserve Funds should be offset by any working Capital or net current asset deficits. The desired level for the Board Designated reserve funds is a minimum of 2.5 and maximum of 3.0 months of capitation revenues and a Statutory reserve between 100% and 110% of Tangible Net Equity (TNE) as specified by CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds. CalOptima Health shall utilize the Tier 1 investment portfolio for the Board-designated Reserve and Tier 2 for Statutory Reserve.
Supranational Institutions	International institutions formed by two (2) or more governments that transcend boundaries to pursue mutually beneficial economic or social goals.
Surplus	Assets beyond liabilities.
Underlying Pool of Securities	Those securities and obligations that are eligible for direct investment by local public agencies.
Valuation	An estimation of the worth of a financial Instrument or asset. CalOptima Health's asset managers provide CalOptima Health with reporting that shows the Valuation of each financial Instrument that they own on behalf of CalOptima Health. Each asset manager uses a variety of market sources to determine individual Valuations.

1

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
5. Approve Modifications to CalOptima Health Capitalization Policy

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

Recommended Action
Approve modifications to CalOptima Health Policy GA.3301: Capitalization Policy.

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

Discussion
The table below outlines a list of substantive changes to GA.3301: Capitalization Policy (Policy), which are reflected in the attached redline Policy. 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).

CalOptima Health last revised the Policy on April 1, 2023. The Policy provides clear and uniform guidance for determining the proper classification of an asset and establish policies and procedures to classify and capitalize assets owned or leased by CalOptima Health.

Section	Proposed Change	Rationale
Section II.G	Add procedures to comply with new Governmental Accounting Standards Board requirements for subscription-based information technology arrangements (SBITAs).	To address applicable accounting standards.
Section III.A	Adjust and provide the capitalization threshold of $25,000 within the policy, rather than having this information only as a defined term in the glossary.	To increase operational efficiency.
Section III.E (revised version)	Add section for Capital Leases to provide procedures and define the materiality threshold of $25,000 for one year of payments.	To address applicable accounting standards.
Section III.F (revised version)	Add section on the recording of intangible assets for SBITAs, including procedures and threshold.	To address applicable accounting standards.

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Fiscal Impact
The recommended action will have a minimal fiscal impact to the CalOptima Health Fiscal Year 2024-25 Capital and Operating Budgets. Staff anticipates the Policy updates will decrease capitalized assets and depreciation expense, and increase other non-salary expense accounts. Staff will monitor the impact of this Policy update and if necessary, bring any material items to a future meeting.

Rationale for Recommendation
Updates to the Policy enhance the efficiency of CalOptima Health's operations and governance, and ensure compliance with applicable accounting standards.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Health Policy GA.3301: Capitalization

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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Policy:	GA.3301
Title:	**Capitalization Policy**
Department:	Finance
Section:	Accounting
CEO Approval:	*/s/*
Effective Date:	11/01/2011
Revised Date:	12/05/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

To provide clear and uniform guidance for determining the proper classification of an Asset and establish policies and procedures to classify and Capitalize Assets owned or leased by CalOptima Health.

II. POLICY

A. CalOptima Health shall establish a consistent process to classify and Capitalize Capital Assets ~~consistently~~that meets the Capitalization Threshold. Capital Assets shall be amortized or depreciated on a Straight-line Method.

B. CalOptima Health shall value new purchases, additions, and replacements at Cost, where Cost includes freight, installation, taxes, and other charges incurred to place the Asset in service.

C. CalOptima Health shall Capitalize major Building structural components, subsystems, and equipment separately based on their Asset class.

D. CalOptima Health shall Capitalize certain Costs associated with Internally Developed and Purchased Commercial Software.

1. CalOptima Health will expense internal and external Costs~~,~~ incurred ~~for Internally Developed Software~~ during the Preliminary Project Stage of Software Development~~, as the Costs are incurred~~.

2. CalOptima Health shall Capitalize internal and external Costs~~,~~ incurred ~~for Internally Developed Software~~ during the Application Development Stage of Software Development.

3. CalOptima Health shall ~~begin Capitalization when the Preliminary~~generally expense internal and external Costs incurred during the Post-Implementation Project Stage of Software Development ~~is complete~~.

   a. The Accounting Department shall review Costs incurred during this stage for enhancements or upgrades that result in new functionality, modules, and/or software capability for Capitalization. These Costs will be Capitalized over the remaining useful life of the original project.

4. CalOptima Health shall cease Capitalization of Internally Developed Software no later than the point at which a computer software project is substantially complete and ready for its intended use, and after all substantial testing is complete, even if not yet launched to users.

~~D. CalOptima Health shall expense internal and external Costs incurred during the Post-Implementation Project Stage of Software Development. Activities in this stage include application training and software maintenance.~~

5. Charges for licensing and monthly vendor maintenance or hosting during all stages of development are expensed in the corresponding month of service.

~~1.~~6. CalOptima Health shall Capitalize Costs to develop or obtain software that allows for access to or conversion of old data by new systems. ~~However, data conversion Costs shall be expensed as incurred.~~

~~E. CalOptima Health shall amortize or depreciate on a Straight-line Method.~~

~~F.~~E. CalOptima Health shall classify all leases in which CalOptima Health is a lessee as ~~either~~a contract financing that conveys the right to use another entity's tangible Asset as specified in the contract for a ~~Capital or operating lease~~period of time in an exchange or exchange-like transaction in accordance with Governmental Accounting Standards Board (GASB) 87 as defined in the June 2017 No. 366 Governmental Accounting Standards Series with a retroactive adoption date of June 15, 2021.

~~G.~~F. CalOptima Health shall Capitalize Assets with component Costs that are less than the Capitalization Threshold for an individual Asset, ~~whereby~~when the ~~asset~~Asset in aggregate is equal to, or greater than the Capitalization Threshold as defined in ~~the Glossary~~Section III.A.

G. CalOptima Health shall establish an intangible Subscription Based Information Technology Arrangements (SBITA) and subscription liability for any qualifying GASB Statement 96, SBITA with a retroactive adoption date of June 15, 2022.

III. PROCEDURE

~~A.~~ CalOptima Health shall Capitalize Assets used in operations with an initial useful life extending beyond one (1) year that also meets the Capitalization Threshold~~.~~

~~B.~~ of twenty-five thousand ($25,000) dollars. The Accounting Department shall enter Capitalized and Controllable Assets into the Fixed Asset module of the accounting software system ~~in accordance with CalOptima Health Policy GA.3302: Asset Management Policy.~~

A. ~~.~~The Accounting Department shall calculate ~~Depreciation~~depreciation using the Straight-line Method effective the first ~~day~~ (1st) day of the subsequent month the Asset was placed in service.

B. The Accounting Department shall reclassify assembled Fixed Assets from Construction In Progress (CIP) to a depreciable Fixed Asset when construction is complete and meets the Capitalization Threshold. ~~.~~The Fixed Asset Cost is the sum of the construction components ~~and service~~.

C. Categories and useful lives of Capitalized Assets shall be as follows:

Categories	Useful Lives
Furniture, fixtures, equipment	5 years
Vehicles	5 years

Categories	Useful Lives
Hardware and Software: Computers/Printers Software – Internal development Costs Software – Commercial	 3 years Based on development stage 3 years
Land, Buildings, and Improvements: Land Buildings	 Not depreciated 40 years
Improvements: –Building Components: —Building shell —Electrical and lighting systems —Elevator systems —Fire protection systems —Fixed equipment —Floor coverings —Heating, ventilation, cooling —Interior finish —Misc. construction features —Plumbing systems —Roof coverings	 Based on ~~components~~Components: 30 years 20 years 20 years 20 years 20 years 15 years 15 years 15 years 15 years 20 years 10 years
–Land Improvements: —Fencing, brick, stone —Fencing, chain link, guardrails —Landscaping —Parking lot, open wall —Paving, asphalt —Water, sewer lines	Based on ~~improvement~~Improvement: 25 years 15 years 10 years 20 years 8 years 20 years
–Leasehold Improvements	The lesser of 15 years or the remaining term of lease
–Tenant Improvements	The lesser of 7 years or the remaining term of lease

1. The Accounting Department may adjust Asset lives as necessary depending on the present condition and use of the Asset and based on how long the Asset is expected to meet current service demands.

D. The Accounting Department shall determine expenditures to Capitalize Buildings as follows:

1. Purchased Buildings

   a. Original purchase price;

   b. Expenses for remodeling, reconditioning, or altering a purchased Building to make it ready to use for the purpose for which it was acquired;

   c. Environmental compliance including, but not limited to, asbestos abatement;

d. Professional fees including, but not limited to, architect, engineer, management fees for design and supervision, and legal services;

e. Payment of unpaid or accrued taxes on the Building to date of purchase;

f. Cancellation or buyout of existing leases; and

g. Other ~~costs~~Costs required to place or render the Asset into operation.

2. Constructed Buildings

a. Completed project Costs;

b. Interest accrued during construction;

c. Cost of excavation, grading or filling of land for a specific Building;

d. Expenses incurred for the preparation of plans including, but not limited, specifications and blueprints;

e. Cost of Building permits;

f. Professional fees including, but not limited to, architect, engineer, management fees for design and supervision, and legal services;

g. Costs of temporary Buildings used during construction;

~~h. Unanticipated Costs including, but not limited to, rock blasting, piling and relocation of the channel of an underground stream;~~

~~i.~~h. Permanently attached fixtures or machinery that cannot be removed without impairing the use of the Building; ~~and~~

~~j.~~i. Additions to Buildings including, but not limited to, expansions, extensions, and enlargements~~.~~; and

~~C. CalOptima Health shall expense internal and external Costs, incurred for Internally Developed Software during the Preliminary Project Stage of Software Development, as the Costs are incurred. All expenditures related to the Preliminary Project Stage are related to the conceptual formulation and evaluation of alternatives, the determination of the existence of needed technology, and the final selection of alternatives for the development of the software.~~

~~D. CalOptima Health shall Capitalize internal and external Costs, incurred for Internally Developed Software during the Application Development Stage of Software Development. Expenditures during the Application Development Stage of Software Development relate to the design of the chosen path, software configuration and interfaces, coding, installation to hardware, testing, and the parallel processing phase. Training Costs, if incurred during this stage, are not considered Internally Developed Software Costs and shall be expensed.~~

j. Unanticipated Costs allowable by GASB.

E. CalOptima Health shall calculate and record Capital Leases for tangible Assets according to the following:

1. A materiality threshold of twenty-five thousand ($25,000) dollars for one (1) year of payments;

2. For those that meet the materiality threshold, the net present value of the sum of the contract's fixed payment schedule at commencement is recorded as a Capital Lease Asset and lease liability;

3. If the contract terms include options to extend or terminate, then these are included in the contract sum when it is reasonably certain that they will be exercised; and

4. The prime rate of interest is used when determining the net present value.

F. CalOptima Health shall record an intangible Asset for a SBITA Arrangement when:

1. The contract conveys control of the right to use another entity's nonfinancial Asset (the underlying Asset) as specified in the contract for a period of time in an exchange or exchange-like transaction;

2. The contract is cancellable for cause;

3. The contract does not transfer ownership of the underlying Asset;

4. The underlying Asset is used to conduct CalOptima Health business;

5. The annual contract Costs are fifty thousand ($50,000) dollars or above based on the informal Micro Purchase limit, pursuant to CalOptima Health Policy GA.5002: Purchasing;

6. The minimum contract is greater than twelve (12) months;

7. If the contract terms include options to extend or terminate, then these are included in the contract sum when it is reasonably certain that they will be exercised; and

8. The prime rate of interest is used when determining the net present value.

IV. ATTACHMENT(S)

~~A. Summary: Capitalization Requirements by Project Development Stage~~
Not Applicable

V. REFERENCE(S)

~~A. CalOptima Health Policy GA.3302: Asset Management Policy~~
~~B.~~A. Governmental Accounting Standards Board (GASB) No. 87; June 2017 No. 366 Governmental Accounting Standards Series
B. Governmental Accounting Standards Board (GASB) No. 96; June 2022
C. CalOptima Health Policy GA.5002: Purchasing

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/03/2022	Regular Meeting of the CalOptima Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2011	GA.3301	Capitalization Policy	Administrative
Revised	03/03/2022	GA.3301	Capitalization Policy	Administrative – Internal only
Revised	04/01/2023	GA.3301	Capitalization Policy	Administrative – Internal only
Revised	12/05/2024	GA.3301	Capitalization Policy	Administrative – Internal only

IX. GLOSSARY

Term	Definition
Application Development Stage of Software Development	The stage of software development related to the enhancement or upgrade of in-house or cloud-based software, including the design of the chosen path, software configuration and interfaces, labor, installation to hardware, testing, and the parallel processing phase.
Asset	A tangible or intangible item of value.
Building	A structure that is permanently attached to the land, has a roof, is partially or completely enclosed by walls and is not intended to be transportable or moveable.
Capital	~~Capital refers to financial~~Financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Capital Lease	A type of lease agreement where the lessee (the company or individual renting the asset) assumes the risks and rewards of ownership of the tangible leased asset. The lessee treats the leased asset as if they purchased and financed it through the lease agreement.
Capitalization Threshold	The threshold for capitalized items is twenty-five thousand ($~~5~~25,000) dollars.
Capitalize	To record an item as an asset rather than an expense such that the expenditure will appear in the balance sheet.
Capitalization	The recording of an item as an asset rather than an expense such that the expenditure will appear in the balance sheet.
Capital Asset	~~Capital Asset:~~ Any asset used in operations with an initial useful life extending beyond one (1) year that also meets the Capitalization Threshold.
Controllable Assets	Certain purchases that do not meet the criteria established for designation as a Capital asset, however, by their nature should be monitored for proper use and disposal. These controllable assets either render a critical function or put the organization at risk by their absence. Such items include but are not limited to laptops, computers, printers, minor furnishings, and general office equipment.
Cost	Cost includes freight, installation, taxes and other charges incurred to place the asset in use. Service and maintenance contracts are charged to prepaid expenses and amortized over the period of the contract.
Fixed Assets	Fixed assets or Capital assets are tangible assets with a value greater than or equal to the Capitalization Threshold and a useful life in excess of one (1) year. Fixed assets include buildings, machinery and equipment, computer equipment, vehicles, improvements, and land.
~~Internally Developed Software~~Micro Purchase	~~Software developed in-house by personnel or by a third-party contractor on behalf of CalOptima Health or commercially available software purchased or licensed by CalOptima Health.~~ Purchase of goods, non-medical professional services, Public Works projects, capital projects, and computer equipment and telecommunications goods and services estimated to cost less than fifty thousand ($50,000) dollars.
Preliminary Project Stage of Software Development	The stage of software development related to the internal development of software that is new to the organization~~.~~, which includes design~~, configuration, interfaces, labor, installation, testing,~~ and evaluations of alternatives.
Post-Implementation Project Stage of Software Development	All expenditures related to the post-implementation of internally developed software. Expenditures include application maintenance, labor, and training.

Term	Definition
Software-Commercial	Commercially available software that requires minimal effort to put into operation. All expenditures related to the initial implementation (excluding equipment or hardware), totaling greater than the Capitalization Threshold, and to be used for more than one (1) year are capitalized.
Software, Internally Developed	Software developed in-house by personnel or by a third-party contractor on behalf of CalOptima Health, or commercially available software purchased or licensed by CalOptima Health that has been modified to a significant degree before being put into use.
Straight-line Method	A method to record the allocation of an asset's cost evenly over its useful life.

Policy:	GA.3301
Title:	**Capitalization Policy**
Department:	Finance
Section:	Accounting
CEO Approval:	*/s/*
Effective Date:	11/01/2011
Revised Date:	12/05/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

To provide clear and uniform guidance for determining the proper classification of an Asset and establish policies and procedures to classify and Capitalize Assets owned or leased by CalOptima Health.

II. POLICY

A. CalOptima Health shall establish a consistent process to classify and Capitalize Capital Assets that meets the Capitalization Threshold. Capital Assets shall be amortized or depreciated on a Straight-line Method.

B. CalOptima Health shall value new purchases, additions, and replacements at Cost, where Cost includes freight, installation, taxes, and other charges incurred to place the Asset in service.

C. CalOptima Health shall Capitalize major Building structural components, subsystems, and equipment separately based on their Asset class.

D. CalOptima Health shall Capitalize certain Costs associated with Internally Developed and Purchased Commercial Software.

1. CalOptima Health will expense internal and external Costs incurred during the Preliminary Project Stage of Software Development.

2. CalOptima Health shall Capitalize internal and external Costs incurred during the Application Development Stage of Software Development.

3. CalOptima Health shall generally expense internal and external Costs incurred during the Post-Implementation Project Stage of Software Development.

    a. The Accounting Department shall review Costs incurred during this stage for enhancements or upgrades that result in new functionality, modules, and/or software capability for Capitalization. These Costs will be Capitalized over the remaining useful life of the original project.

4. CalOptima Health shall cease Capitalization of Internally Developed Software no later than the point at which a computer software project is substantially complete and ready for its intended use, and after all substantial testing is complete, even if not yet launched to users.

5. Charges for licensing and monthly vendor maintenance or hosting during all stages of development are expensed in the corresponding month of service.

6. CalOptima Health shall Capitalize Costs to develop or obtain software that allows for access to or conversion of old data by new systems.

E. CalOptima Health shall classify all leases in which CalOptima Health is a lessee as a contract financing that conveys the right to use another entity's tangible Asset as specified in the contract for a period of time in an exchange or exchange-like transaction in accordance with Governmental Accounting Standards Board (GASB) 87 as defined in the June 2017 No. 366 Governmental Accounting Standards Series with a retroactive adoption date of June 15, 2021.

F. CalOptima Health shall Capitalize Assets with component Costs that are less than the Capitalization Threshold for an individual Asset, when the Asset in aggregate is equal to, or greater than the Capitalization Threshold as defined in Section III.A.

G. CalOptima Health shall establish an intangible Subscription Based Information Technology Arrangements (SBITA) and subscription liability for any qualifying GASB Statement 96, SBITA with a retroactive adoption date of June 15, 2022.

III. PROCEDURE

A. CalOptima Health shall Capitalize Assets used in operations with an initial useful life extending beyond one (1) year that also meets the Capitalization Threshold of twenty-five thousand ($25,000) dollars. The Accounting Department shall enter Capitalized and Controllable Assets into the Fixed Asset module of the accounting software system. The Accounting Department shall calculate depreciation using the Straight-line Method effective the first (1st) day of the subsequent month the Asset was placed in service.

B. The Accounting Department shall reclassify assembled Fixed Assets from Construction In Progress (CIP) to a depreciable Fixed Asset when construction is complete and meets the Capitalization Threshold. The Fixed Asset Cost is the sum of the construction components.

C. Categories and useful lives of Capitalized Assets shall be as follows:

Categories	Useful Lives
Furniture, fixtures, equipment	5 years
Vehicles	5 years
Hardware and Software: Computers/Printers Software – Internal development Costs Software – Commercial	 3 years Based on development stage 3 years
Land, Buildings, and Improvements: Land Buildings	 Not depreciated 40 years
Improvements: Building Components: Building shell Electrical and lighting systems	 Based on Components: 30 years 20 years

Categories	Useful Lives
Elevator systems	20 years
Fire protection systems	20 years
Fixed equipment	20 years
Floor coverings	15 years
Heating, ventilation, cooling	15 years
Interior finish	15 years
Misc. construction features	15 years
Plumbing systems	20 years
Roof coverings	10 years
Land Improvements:	Based on Improvement:
Fencing, brick, stone	25 years
Fencing, chain link, guardrails	15 years
Landscaping	10 years
Parking lot, open wall	20 years
Paving, asphalt	8 years
Water, sewer lines	20 years
Leasehold Improvements	The lesser of 15 years or the remaining term of lease
Tenant Improvements	The lesser of 7 years or the remaining term of lease

1. The Accounting Department may adjust Asset lives as necessary depending on the present condition and use of the Asset and based on how long the Asset is expected to meet current service demands.

D. The Accounting Department shall determine expenditures to Capitalize Buildings as follows:

1. Purchased Buildings

   a. Original purchase price;

   b. Expenses for remodeling, reconditioning, or altering a purchased Building to make it ready to use for the purpose for which it was acquired;

   c. Environmental compliance including, but not limited to, asbestos abatement;

   d. Professional fees including, but not limited to, architect, engineer, management fees for design and supervision, and legal services;

   e. Payment of unpaid or accrued taxes on the Building to date of purchase;

   f. Cancellation or buyout of existing leases; and

   g. Other Costs required to place or render the Asset into operation.

2. Constructed Buildings

   a. Completed project Costs;

   b. Interest accrued during construction;

c. Cost of excavation, grading or filling of land for a specific Building;

d. Expenses incurred for the preparation of plans including, but not limited, specifications and blueprints;

e. Cost of Building permits;

f. Professional fees including, but not limited to, architect, engineer, management fees for design and supervision, and legal services;

g. Costs of temporary Buildings used during construction;

h. Permanently attached fixtures or machinery that cannot be removed without impairing the use of the Building;

i. Additions to Buildings including, but not limited to, expansions, extensions, and enlargements; and

j. Unanticipated Costs allowable by GASB.

E. CalOptima Health shall calculate and record Capital Leases for tangible Assets according to the following:

1. A materiality threshold of twenty-five thousand ($25,000) dollars for one (1) year of payments;

2. For those that meet the materiality threshold, the net present value of the sum of the contract's fixed payment schedule at commencement is recorded as a Capital Lease Asset and lease liability;

3. If the contract terms include options to extend or terminate, then these are included in the contract sum when it is reasonably certain that they will be exercised; and

4. The prime rate of interest is used when determining the net present value.

F. CalOptima Health shall record an intangible Asset for a SBITA Arrangement when:

1. The contract conveys control of the right to use another entity's nonfinancial Asset (the underlying Asset) as specified in the contract for a period of time in an exchange or exchange-like transaction;

2. The contract is cancellable for cause;

3. The contract does not transfer ownership of the underlying Asset;

4. The underlying Asset is used to conduct CalOptima Health business;

5. The annual contract Costs are fifty thousand ($50,000) dollars or above based on the informal Micro Purchase limit, pursuant to CalOptima Health Policy GA.5002: Purchasing;

6. The minimum contract is greater than twelve (12) months;

7. If the contract terms include options to extend or terminate, then these are included in the contract sum when it is reasonably certain that they will be exercised; and

8. The prime rate of interest is used when determining the net present value.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Governmental Accounting Standards Board (GASB) No. 87; June 2017 No. 366 Governmental Accounting Standards Series
B. Governmental Accounting Standards Board (GASB) No. 96; June 2022
C. CalOptima Health Policy GA.5002: Purchasing

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/03/2022	Regular Meeting of the CalOptima Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2011	GA.3301	Capitalization Policy	Administrative
Revised	03/03/2022	GA.3301	Capitalization Policy	Administrative – Internal only
Revised	04/01/2023	GA.3301	Capitalization Policy	Administrative – Internal only
Revised	12/05/2024	GA.3301	Capitalization Policy	Administrative – Internal only

IX. GLOSSARY

Term	Definition
Application Development Stage of Software Development	The stage of software development related to the enhancement or upgrade of in-house or cloud-based software, including the design of the chosen path, software configuration and interfaces, labor, installation to hardware, testing, and the parallel processing phase.
Asset	A tangible or intangible item of value.
Building	A structure that is permanently attached to the land, has a roof, is partially or completely enclosed by walls and is not intended to be transportable or moveable.
Capital	Financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Capital Lease	A type of lease agreement where the lessee (the company or individual renting the asset) assumes the risks and rewards of ownership of the tangible leased asset. The lessee treats the leased asset as if they purchased and financed it through the lease agreement.
Capitalization Threshold	The threshold for capitalized items is twenty-five thousand ($25,000) dollars.
Capitalize	To record an item as an asset rather than an expense such that the expenditure will appear in the balance sheet.
Capitalization	The recording of an item as an asset rather than an expense such that the expenditure will appear in the balance sheet.
Capital Asset	Any asset used in operations with an initial useful life extending beyond one (1) year that also meets the Capitalization Threshold.
Controllable Assets	Certain purchases that do not meet the criteria established for designation as a Capital asset, however, by their nature should be monitored for proper use and disposal. These controllable assets either render a critical function or put the organization at risk by their absence. Such items include but are not limited to laptops, computers, printers, minor furnishings, and general office equipment.
Cost	Cost includes freight, installation, taxes and other charges incurred to place the asset in use. Service and maintenance contracts are charged to prepaid expenses and amortized over the period of the contract.
Fixed Assets	Fixed assets or Capital assets are tangible assets with a value greater than or equal to the Capitalization Threshold and a useful life in excess of one (1) year. Fixed assets include buildings, machinery and equipment, computer equipment, vehicles, improvements, and land.
Micro Purchase	Purchase of goods, non-medical professional services, Public Works projects, capital projects, and computer equipment and telecommunications goods and services estimated to cost less than fifty thousand ($50,000) dollars.
Preliminary Project Stage of Software Development	The stage of software development related to the internal development of software that is new to the organization, which includes design and evaluations of alternatives.
Post-Implementation Project Stage of Software Development	All expenditures related to the post-implementation of internally developed software. Expenditures include application maintenance, labor, and training.
Software-Commercial	Commercially available software that requires minimal effort to put into operation. All expenditures related to the initial implementation (excluding equipment or hardware), totaling greater than the Capitalization Threshold, and to be used for more than one (1) year are capitalized.

Term	Definition
Software, Internally Developed	Software developed in-house by personnel or by a third-party contractor on behalf of CalOptima Health, or commercially available software purchased or licensed by CalOptima Health that has been modified to a significant degree before being put into use.
Straight-line Method	A method to record the allocation of an asset's cost evenly over its useful life.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

6. Adopt Resolution No. 24-1205-01 Liquidation and Transfer of Assets from Public Agency Retirement Services to Empower Trust Company, LLC

Contacts

Michael Hunn, Chief Executive Officer, (714) 246-8570
Steve Eckberg, Chief Human Resources Officer, (657) 328-9053

Recommended Actions

Adopt Resolution No. 24-1205-01 approving the liquidation and transfer of assets from Public Agency Retirement Services to Empower Trust Company, LLC and termination of associated agreements upon successful transfer of assets.

Background

On January 5, 1999, the CalOptima Health Board of Directors (Board) approved the establishment of a Supplemental Retirement Plan (SRP) for CalOptima Health employees, appointed members to an SRP Committee, authorized the SRP Committee to take necessary actions to adopt and implement an SRP plan document, appointed the Director of Human Resources as the plan administrator, authorized the Chair of the Board and/or the Chief Executive Officer (CEO) to appoint and/or remove members of the SRP Committee, and authorized the CEO to determine the employer contribution to the SRP consistent with the previous authority given to set employee compensation and benefits within the limits of the budget. CalOptima Health contracted with the Public Agency Retirement Services (PARS) in 1999 to implement and administer the SRP, a 401(a) tax-qualified multiple employer trust.

Since that time, PARS has served as the Trust Administrator. John Hancock Retirement Services is the custodian of plan assets and the record keeper of the plan. Through John Hancock, PARS participants have the ability to self-direct investments by selecting a variety of no-load mutual funds. However, CalOptima Health's SRP Committee cannot direct changes to the PARS/Hancock 401(a) plan investment menu because the plan is structured as a multiple employer arrangement and all participating employers must maintain the same investment menu. To ensure that CalOptima Health maintains its fiduciary responsibility in how its supplemental retirement benefits are managed, the Board took action at the June 6, 2024, Board meeting regarding the supplemental employee benefit plan. The Board (i) authorized staff to develop a scope of work and release the request for proposals for an SRP administrator; and (ii) authorized the CEO to select a vendor and negotiate and execute a contract with the selected vendor. Through this process, Empower Retirement, LLC (Empower) was selected as the successor SRP administrator.

The SRP is currently funded by an employer contribution of four percent (4%) of employee base earnings. The SRP Committee reviews the plan's asset allocations and the performance of the plan's investment alternatives on a quarterly basis. Total plan assets as of October 15, 2024, are $71,246,628.

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Discussion
For the current SRP, PARS currently serves as the Trust Administrator, U.S. Bank National Association (U.S. Bank) serves as the Trustee, and John Hancock Retirement Services serves as custodian of plan assets and the record keeper of the plan. With the selection of Empower, PARS and U.S. Bank were provided with a termination notice on October 1, 2024. Assets managed by PARS and U.S. Bank need to be transferred to Empower Trust Company, LLC (Empower Trust), which will serve as the successor trustee of the SRP.

In order to complete the transfer of plan assets, a Board-approved resolution that authorizes the following actions is necessary:

1) The replacement of the CalOptima PARS Defined Contribution Plan with the CalOptima Health 401a Defined Contribution Plan administered by Empower effective January 2, 2025;
2) The appointment and acceptance of Empower Trust as the successor trustee;
3) The liquidation of PARS Defined Contribution Plan assets and transfer of all assets to Empower Trust, which would occur on or around January 15, 2025, or as soon as administratively practicable thereafter;
4) Upon the complete and successful transfer of all asset to Empower Trust, the removal of PARS as Trust Administrator, U.S. Bank as Trustee, and John Hancock Retirement Services as Custodian/Recordkeeper; and
5) The CalOptima Health Chief Executive Officer to take such actions as are necessary to carry out the purpose and intent of the resolution.

The SRP Committee recommends the replacement of the PARS Defined Contribution Plan with the CalOptima Health 401a Defined Contribution Plan administered by Empower effective January 2, 2025.

Fiscal Impact
The recommended action has no fiscal impact. The estimated cost for the SRP administrator contract has been included in the Fiscal Year 2024-25 Operating Budget.

Rationale for Recommendation
These actions ensure that CalOptima Health maintains its fiduciary responsibility in how its supplemental retirement benefits are managed.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Adopt Resolution No. 24-1205-01 Liquidation and Transfer of Assets from Public Agency Retirement Services (PARS) to Empower Trust Company, LLC

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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RESOLUTION NO. 24-1205-01

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

LIQUIDATION AND TRANSFER OF ASSETS FROM PUBLIC AGENCY RETIREMENT SERVICES TO EMPOWER TRUST COMPANY, LLC

WHEREAS, CalOptima Health ("**CalOptima**") is a local public agency created pursuant to Welfare and Institutions Code section 14087.54 by the County of Orange under Orange County Ordinance No. 3896, as amended, which established CalOptima as a separate and distinct public entity;

WHEREAS, at the January 5, 1999, Board of Directors ("**Board**") meeting, the Board took actions regarding a supplemental employee benefit plan, including (i) authorizing the establishment of a supplemental retirement benefit plan for CalOptima Health employees effective January 1, 1999; (ii) establishing a supplemental retirement plan committee and appointing the initial members; (iii) directing and authorizing the committee to take necessary actions to adopt and implement a plan document in compliance with applicable laws and regulations; and (iv) appointed the Director of Human Resources as the plan administrator with authorization to take necessary actions to implement and administer the plan in compliance with the plan and applicable legal requirements;

WHEREAS, the Public Agency Retirement System ("**PARS**") was selected to administer the supplemental retirement benefit plan;

WHEREAS, the CalOptima PARS Defined Contribution Plan was adopted effective January 1, 1999, and outlines the terms of the supplemental benefit plan authorized by the Board, last amended and restated January 1, 2011;

WHEREAS, CalOptima PARS Defined Contribution Plan funds are held in a trust established to hold the assets of the plan for the exclusive benefits of plan participants or their beneficiaries as authorized by law;

WHEREAS, at the June 6, 2024, Board meeting, the Board (i) authorized staff to develop a scope of work and release a request for proposals for a supplemental retirement plan administrator; and (ii) authorized the Chief Executive Officer to select a vendor and negotiate and execute a contract with the selected vendor;

WHEREAS, pursuant to the Board's authorization to issue a request for proposals, Empower Retirement, LLC was selected to administer CalOptima's supplemental retirement plan;

WHEREAS, pursuant to the selection of Empower Retirement, LLC to administer CalOptima's supplemental retirement plan, Empower Trust Company, LLC and assets must be transferred from the current trustee;

WHEREAS, CalOptima issued a termination notice to PARS and U.S. Bank National Association ("**U.S. Bank**") on October 1, 2024, of CalOptima's intent to terminate agreements in connection with CalOptima's supplemental retirement plan; and

WHEREAS, a Board resolution is necessary to effectuate the liquidation and transfer of assets of the PARS Defined Contribution Plan to Empower Trust Company, LLC.

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NOW, THEREFORE, BE IT RESOLVED:

I. That the CalOptima PARS Defined Contribution Plan administered by PARS is hereby replaced with the CalOptima Health 401a Defined Contribution Plan administered by Empower Retirement LLC, effective January 2, 2025.

II. That Empower Trust Company, LLC is hereby appointed as successor trustee and accepts appointment as successor trustee ("**Successor Trustee**").

III. That the Board hereby authorizes the liquidation of assets of the CalOptima PARS Defined Contribution Plan and authorizes the transfer of all assets to Successor Trustee to be held in trust for participants and beneficiaries of the CalOptima Health 401a Defined Contribution Plan. The liquidation and transfer of assets shall occur on or around January 15, 2025, or as soon as administratively practicable thereafter.

IV. That upon the complete and successful transfer of all assets to Successor Trustee, the following shall take effect in relation to the CalOptima PARS Defined Contribution Plan:

a. PARS shall be removed as Trust Administrator;
b. U.S. Bank shall be removed as Trustee;
c. John Hancock Retirement Services shall be removed as Custodian/Recordkeeper; and
d. Any accounts and agreements associated with the CalOptima PARS Defined Contribution Plan shall be terminated.

V. That the CalOptima Health Chief Executive Officer is hereby authorized to take such actions as are necessary to carry out the purpose and intent of this resolution and shall direct the Plan Administrator for the CalOptima PARS Defined Contribution Plan to take action as necessary to carry out the purpose and intent of this resolution.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 5th day of December, 2024.

AYES: _____

NOES: _____

ABSENT: _____

ABSTAIN: _____

/s/_____
Printed Name and Title: Isabel Becerra, Chair, CalOptima Health Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Authorize Change to Supplemental Retirement Plan Vesting Schedule

Contacts

Michael Hunn, Chief Executive Officer, (714) 246-8570
Steve Eckberg, Chief Human Resources Officer, (657) 328-9053

Recommended Actions

Authorize the vesting schedule change for the Supplemental Retirement Plan from quarterly to annual, including one-time adjustments to the next tier for employees who are not yet fully vested, effective January 2, 2025.

Background

On January 5, 1999, the CalOptima Health Board of Directors (Board) approved the establishment of a Supplemental Retirement Plan (SRP) for CalOptima Health employees. CalOptima Health contracted with Public Agency Retirement Services (PARS) in 1999 to implement and administer the SRP, a 401(a) tax-qualified multiple employer trust. PARS has been the administrator of the SRP since that time.

The SRP is currently funded by an employer contribution of four percent (4%) of employee base earnings. All regular full and part-time CalOptima Health employees participate in the SRP program and are subject to the following quarterly vesting schedule:

Quarters of Service Completed	Percent Vested
0-3	0.00%
4	25.00%
5	31.25%
6	37.50%
7	43.75%
8	50.00%
9	56.25%
10	62.50%
11	68.75%
12	75.00%
13	81.25%
14	87.50%
15	93.75%
16	100.00%

Employees are fully vested in their employer contribution account after completing at least sixteen (16) quarters of service, or the equivalent of four (4) years. If the employee terminates employment with

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CalOptima Health and is not fully vested in their employer contribution account, they forfeit the unvested portion. All forfeited amounts are transferred to a single forfeiture account, which is utilized to offset future employer contributions or to pay plan administrative fees. As of October 15, 2024, the forfeiture account has a balance of $145,113.38.

There are currently 2,445 PARS participant accounts, including both active and separated employees. As of October 15, 2024, the total account balance is $71,246,628.01.

Discussion

As a result of a recent request for proposals process authorized by the Board in June 2024, CalOptima Health selected Empower Retirement LLC as the successor SRP administrator with a transition date of January 2, 2025, or as soon as administratively possible. In transitioning the SRP from PARS to Empower, a new plan document for the "CalOptima Health 401a Defined Contribution Plan" will be prepared. During plan design discussions, staff were advised that Empower cannot accommodate a quarterly vesting schedule. However, Empower does offer an annual vesting schedule option that would closely align with CalOptima Health's current quarterly vesting schedule at each yearly service milestone. Under the annual vesting schedule, active employees with one year of service will be 25% vested at the completion of the service year, two years of service will be 50% vested, three years of service will be 75% vested, and four years of service will be 100% vested. To facilitate future vesting rate changes, those employees who have over one year of service, are employed at the time of the transition to Empower and are not yet fully vested may have an "adjusted vesting service date" of January 2, 2025, rather than basing their vesting calculations on date of hire.

Internal Revenue Code (IRC) Sections 411(a)(10)(A) and Section 411(d)(6) establish an anti-cutback rule that provides that the accrued benefit of a participant in a qualified retirement plan may not be decreased by an amendment to the plan, including changes to vesting schedules. Any change to the plan that would reduce or eliminate the benefit is not permitted. Due to the anti-cutback rule, the new vesting schedule must be equal to or more generous than the existing schedule. This schedule change will have a fiscal impact if an employee with less than four years of service separates from employment. There are approximately 600 active employees with less than four years of service. As such, the SRP Committee proposes the following annual vesting schedule and movement of staff who are not fully vested:

Quarters of Service Completed (Current)	**Percent Vested (Current)**	***Annual Vesting Schedule***	***Vesting Date To Be Used at Time of Transition***	***Proposed Vesting for Transitioning Employees %***
0-3	0.00%		*Date of Hire*	*0.00%*
4	25.00%	*1 Year*	*January 2, 2025*	*25.00%*
5	31.25%		*January 2, 2025*	*50.00%*
6	37.50%		*January 2, 2025*	*50.00%*
7	43.75%		*January 2, 2025*	*50.00%*
8	50.00%	*2 Years*	*January 2, 2025*	*50.00%*
9	56.25%		*January 2, 2025*	*75.00%*
10	62.50%		*January 2, 2025*	*75.00%*
11	68.75%		*January 2, 2025*	*75.00%*
12	75.00%	*3 Years*	*January 2, 2025*	*75.00%*

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13	81.25%		*Date of Hire*	*100.00%*
14	87.50%		*Date of Hire*	*100.00%*
15	93.75%		*Date of Hire*	*100.00%*
16	100.00%	*4 Years*	*Date of Hire*	*100.00%*

The vesting schedule for employees hired on or after January 2, 2025, will be as follows:

Years of Service Completed	***Percent Vested***
Less than 1 Year	*0.00%*
1 Year	*25.00%*
2 Years	*50.00%*
3 Years	*75.00%*
4 Years	*100.00%*

Separated employees will also have their full account balances transferred to Empower. However, any employees who have separated from employment on or before January 1, 2025, and who are not fully vested will be subject to their vested percentage determined under the prior quarterly vesting schedule, and their vested balances will be tracked and reported by Empower accordingly.

The SRP Committee recommends replacing the quarterly vesting schedule with an annual vesting schedule for the CalOptima Health 401a Defined Contribution Plan to be administered by Empower Retirement LLC beginning on January 2, 2025.

Fiscal Impact
The SRP is a budgeted item in the Fiscal Year 2024-25 Operating Budget. Staff estimates the budgeted amounts will be sufficient to support the vesting schedule change from quarterly to annually, and the estimated cost of transitioning employees to the next tier in the current fiscal year.

Rationale for Recommendation
These actions ensure that CalOptima Health continues to manage its supplemental retirement benefits in a manner compliant with the IRC, allows outsourcing of SRP administrative functions to a qualified provider, and conforms CalOptima Health's prior unusual quarterly vesting schedule to an annual schedule that is more typically used by similar governmental employers operating similar retirement benefit programs.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Adopt Resolution No. 24-1205-02 Approving and Adopting Updated CalOptima Health Human Resources Policies

Contacts

Michael Hunn, Chief Executive Officer, (714) 246-8570
Steve Eckberg, Chief Human Resources Officer (657) 328-9053

Recommended Actions

Adopt Resolution No. 24-1205-02 approving updated CalOptima Health policies:

a. GA.8037: Leave of Absence;
b. GA.8040: Family and Medical Leave Act (FMLA) / California Family Rights Act (CFRA) Leaves of Absence;
c. GA.8041: Workers' Compensation Program; and
d. GA.8060: Recruitment, Selection and Hiring.

Background

Near CalOptima Health's inception, the Board of Directors (Board) delegated authority to the Chief Executive Officer to develop and implement employee policies and procedures and to amend them as appropriate from time to time, subject to bi-annual updates to the Board. CalOptima Health's Bylaws require that the Board adopt by resolution, and from time to time amend, procedures, practices, and policies for, among other things, hiring employees and managing personnel.

Discussion

Staff includes the list of revised policies for Board approval and a summary of changes for the updated policies.

GA.8037: Leave of Absence: This policy outlines the general rules and restrictions applicable to a Leave of Absence (LOA).

Policy Section	Proposed Change	Rationale	Impact
II.B	Add language that a Leave of Absence Request Form need not be completed for an Administrative Leave.	Employees are placed on Administrative Leave by Human Resources. This is not a leave that employees request.	Aligns with Human Resources past practice of placing employees on administrative leave without a request form.

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II.E.11	Update to reflect new glossary term, PTO Exhaustion, to define what constitutes exhausting all PTO accruals.	Provides clarity on term used multiple times in policy without repeating the definition throughout.	Provides clarity for term used in multiple policies.
II.E.16	Minor text edits to clarify information of reproductive loss and align with language edits in Employee Handbook.	Provides clarity and consistency.	Provides clarity for staff who experience a reproductive loss event.
II.E.17	Add CalOptima Health leave of absence: Administrative Leave.	References a leave of absence that is discussed in CalOptima Health Policy GA.8022 Performance and Behavior Standards.	Ensures that all CalOptima Health leave of absence policies are referenced in this overarching policy.
III.B	Remove language regarding electing not to use PTO (added to new section below), and update to reflect new glossary term, PTO Exhaustion.	Provides clarity and conciseness. Allows for better consistency in implementing the policy.	Provides clarity and consistency in other policies.
III.C	Add section specific to the use of PTO on leaves, including when it must be used, timing, increments, and coordination with disability benefits.	Sets clear expectations for employees. Allows for better consistency in implementing the policy.	Promotes clear understanding for employees on the use of PTO in relation to leave of absence.
III.D	Add language regarding Flex Holiday hours for those on LOA (on December 31) to be added upon return to active status, or not added if the employee separates employment without returning to active status from their LOA.	For consistency with CalOptima Health Policy GA.8056: Paid Holidays	Provides consistency with other policies and clarity for employees.
III.E	Move Benefit Income from the “not eligible” list to the “may be eligible” list of Supplemental Compensation during LOA.	Aligns with practice.	Provides clarity on practice.
III.J.	Section rewritten to (i) encompass Status of Employee Benefits during PDL, FMLA, CFRA, Military Service or Workers’ Compensation LOA, including when an employee is eligible for employer contributions; (ii) outline when the employee is responsible for both	Sets clear expectations for employees and allows for better consistency in implementing the policy.	Provides clarity and consistency.

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	employee and employer premium payments for coverage under COBRA; (iii) specify consequences for failure to pay premiums when the employee is responsible for both employee and employer portions; and (iv) reinstatement of benefits after return to work from a LOA.		
X	Add Glossary Term: PTO Exhaustion.	Provides clarity and reduces duplicative text within body of policy.	Provides clarity and consistency with other policies.

GA.8040: Family and Medical Leave Act / California Family Rights Act Leaves of Absence: This policy outlines the Leave of Absence (LOA) protocols for employees eligible under the Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA).

Policy Section	Proposed Change	Rationale	Impact
II.B.4	Add "including work-related injury or illness" to employee's own serious health conditions.	Workers' compensation leave of absence runs concurrently with FMLA and/or CFRA.	Confirms standard practice of running FMLA/CFRA leave entitlement concurrently with workers' compensation leave of absence.
II.F	Update to reflect new glossary term, PTO Exhaustion, to define what constitutes exhausting all PTO accruals.	Provides clarity on term used multiple times in policy without repeating the definition throughout.	Provides clarity for term used in multiple policies.
II.F	Add section specific to the use of PTO on leaves, including when it must be used, timing, and increments.	Provides clarification on the use of PTO and consistency with new policy term of PTO Exhaustion.	Promotes clear understanding for employees on the use of PTO in relation to FMLA/CFRA leave of absence.
II.F.1	Add statement regarding ability to make a one-time request to coordinate disability benefits with accrued PTO.	Makes policy consistent with recent changes to other leave policies.	Ensures that employees on a FMLA/CFRA leave of absence only make an election to

			coordinate disability payments at the beginning of their leave.
II.I.1.	Update text regarding CalOptima Health's payment of employer contributions toward health benefits.	Reworded for clarity and to align with other leave policies.	Provides clarity on practice.
II.I.3	Move text regarding responsibility for health insurance premium after exhausting FMLA/CFRA leave to new section II.I.7.	Provides clarity and new section expands on the topic.	None.
II.I.4	Update text regarding termination of coverage due to untimely payment of premiums.	Reworded for clarity.	Confirms standard practice of terminating health insurance coverage due to failure to pay for insurance premiums.
II.I.5	Remove statement regarding Evidence of Insurance (EOI) and preexisting clauses. Added statement about benefit coverage if an employee returns to a subsequent LOA.	EOI and preexisting conditions are not applicable to CalOptima Health's group health insurance plans. Benefit coverage statement is consistent with recent changes to other leave policies.	Removes language that is not applicable to CalOptima Health's medical plans.
II.I.7	Add new section that includes text moved from section II.I.3. Expands on responsibility for premium payments after the employee exhausts FMLA/CFRA leave and remains on a Personal LOA, including CalOptima Health's non-payment of group health insurance premiums when the employee reaches PTO exhaustion or elects not to use PTO, and full employee responsibility of health insurance premiums through COBRA for any remaining portion of the leave.	Provide clarity and is consistent with recent changes to other leave policies.	Employees whose employment is inactive due to protected leave and PTO exhaustion (or electing not to use PTO) are responsible for paying the full share of health insurance premiums, if elected, for the duration of their leave.

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III.Employee.6-7	Update and add to statement regarding payment of health insurance premiums for Personal LOAs after exhaustion of approved FMLA and/or CFRA leave.	Provides clarity and makes policy consistent with other leave policies.	Confirms practice of employees on a Personal LOA paying their share of health insurance premiums while using their accrued PTO.
I.X. Glossary	Add term: Paid Time Off (PTO) Exhaustion.	Define a term used in the policy and make policy consistent with other recently updated leave policies.	Provides clarity and consistency with other policies.

GA.8041: Workers' Compensation Program: This policy outlines CalOptima Health's protocols and procedures for employees who sustain a work-related injury or illness.

Policy Section	Proposed Change	Rationale	Impact
II.E.2.a	Add sub-bullet regarding exhaustion of FMLA/CFRA leave with potential eligibility for Personal LOA. Includes language regarding concurrent LOAs and the interactive process.	Connects Workers' Compensation LOA with Personal LOA for the purpose of addressing how benefits will be administered when FMLA/CFRA is exhausted.	Addresses how benefits will be handled for employees who exhaust FMLA/CFRA while on Workers' Compensation leave, in accordance with practice.
II.F.3	Add language regarding requesting coordination of PTO and disability payments, PTO Exhaustion, and how PTO must be applied.	To align policy with revised language in policy GA.8037: Leave of Absence.	Promotes clear understanding for employees on the use of PTO in relation to Workers' Compensation leave of absence.
III.G	Add language to include Human Resources' partnership with other CalOptima Health departments and workers' compensation third-party administrator when evaluation	Expands Human Resources' ability to find transitional, modified, or alternative work assignments for	Reduces the amount of leave that an employee with a work-related injury or

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	transitional, modified, or alternative work assignments.	employees who have been released to return to work with limitations.	illness must take, by offering more opportunities for transitional, modified, or alternative work assignments.
III.J	Add language specifying that supplemental compensation eligibility for a continuous LOA will be in accordance with CalOptima Health Policy GA.8037 Leave of Absence.	Provides one clear source of eligibility information for supplemental compensation.	Addresses how supplemental compensation will be applied in cases of continuous Workers' Compensation leaves of absence.
IX. Glossary	Added new glossary terms: Continuous Leave of Absence (LOA) and Paid Time Off (PTO) Exhaustion.	Provides clarity for terms used in the policy.	Provides clarity and consistency with other policies.

GA.8060: Recruitment, Selection and Hiring: This policy establishes merit-based hiring practices as the foundation of CalOptima Health's personnel administration, including recruitment, selection, and hiring.

Policy Section	Proposed Change	Rationale	Impact
II.C	Add updated "regular" positions to reflect "regular staff and leadership" positions.	Incorporates NCQA Health Equity (HE) 1 Workgroup recommendation and aligns with NCQA HE 1A language.	Prepares CalOptima Health for future NCQA HE accreditation.
II.C and II.C.2	Move interns, as needed, temporary/seasonal, residents, and fellow positions to those positions that the policy does not apply to.	To support business needs for non-regular (full-time equivalent) staff positions.	Promotes clarity for which CalOptima Health positions are subject to merit-based hiring practices.
III.B.1	Update Job Announcements section to include "various" external employment websites with the intent "to attract a diverse pool of qualified applicants". Explains minimum contents of all job announcements, which will include	Incorporates NCQA HE 1 Workgroup recommendation and aligns with NCQA Health Equity (HE) 1A language and recommendations.	Prepares CalOptima Health for future NCQA HE accreditation.

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	gender neutral language and CalOptima Health's Diversity, Equity and Inclusion and disability accommodation statements.		
III.C.1-3	Format Qualification of Applicants section into 3 bullets. Add text regarding rehire eligibility to be determined following a comprehensive employment history, historical performance evaluations, corrective actions, and reason for separation. Replace "lack of minimum qualifications" with "failure to meet eligibility."	Provides clarity on applicant qualification when applicant is seeking reemployment.	Those applicants seeking to be rehired at CalOptima Health will participate in a comprehensive review of historical performance evaluations, corrective actions, and reason for separation.
III.E.1	Add statement that "HR shall have the authority to disqualify the Chair and/or panel members and appoint new panel members if there are signs of potential bias."	Aligns policy with practice.	Promotes a fair, job-related, and merit-based selection process free from bias.
III.F.3.d	Add requirement that "[c]ompleted interview guides shall be submitted directly to HR no later than twenty-four (24) hours after the completion of the interview."	Sets clear expectations for interview panelists.	Measures reduce bias, common rating errors and candidate comparison, and prevent some candidates from falling out of the selection process due to delays.
III.F.6	Add text that interview panel raters will receive instruction on evaluation standards and prior to serving on an interview panel as a member or Chair.	Aligns policy with practice.	Ensures that interview panel members are better prepared for CalOptima Health's evaluation standards and procedures.
III.F.7	Add statement that "[i]f multiple positions are hired from the same recruitment, the applicant selected	Provides clarity and aligns policy with practice.	Provides guidance on how Hiring Managers

	initially will be removed from the scoring to determine the next three (3) highest scoring applicants."		handle the selection of candidates for multiple positions.
III.G.	Move rehire information to section II.C.2.	Provides clarity and aligns with qualifications.	None.
V. References	Add reference to CalOptima Health Recruitment, Selection and Hiring Guidelines.	Provides additional resource and reference for clarity.	Associates Recruitment, Selections and Hiring Guidelines with policy.
IX. Glossary	Update defined term for Paid Intern and add Unpaid Intern defined term.	Align with terms in CalOptima Health Policy GA.8031: Internship Program	Policy alignment and clarity in definitions.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2024-25 Operating Budget.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Adopt Resolution No. 24-1201-02 Approving and Adopting Updated CalOptima Health Human Resources Policies
2. GA.8037: Leave of Absence;
3. GA.8040: Family and Medical Leave Act (FMLA) / California Family Rights Act (CFRA) Leaves of Absence;
4. GA.8041: Workers' Compensation Program;
5. GA.8060: Recruitment, Selection and Hiring.

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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RESOLUTION NO. 24-1205-02

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

APPROVE UPDATED CALOPTIMA HEALTH POLICIES

WHEREAS, Section 13.1 of the CalOptima Health Bylaws provides that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices, and policies for, inter alia, hiring employees, and managing personnel;

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima Health employees at will, to set compensation within the boundaries of the budget limits set by the Board of Directors, to promulgate employee policies and procedures, and to amend said policies and procedures from time to time, subject to annual review by the Board of Directors, or a committee appointed by the Board of Directors for that purpose; and

WHEREAS, staff has revised certain policies and now presents those revised policies to the Board of Directors for approval.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the following updated CalOptima Health policies:

- GA.8037: Leave of Absence;
- GA.8040: Family and Medical Leave Act (FMLA) / California Family Rights Act (CFRA) Leaves of Absence;
- GA.8041: Workers' Compensation Program; and
- GA.8060: Recruitment, Selection and Hiring.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima Health this 5th day of December 2024.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Isabel Becerra, Chair, CalOptima Health Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

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Policy:	GA.8037
Title:	**Leave of Absence**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines the general rules and restrictions applicable to a Leave of Absence (LOA).

II. POLICY

A. CalOptima Health shall comply with all applicable state and federal LOA laws and regulations and will implement and administer changes to entitlements as required by law.

B. CalOptima Health will grant a LOA to eligible employees in accordance with CalOptima Health's respective policies and procedures. For leaves specified herein with the exception of Administrative Leave, an employee must submit a Leave of Absence Request Form, available on the InfoNet, to the Human Resources (HR) Department.

C. An employee's manager may approve up to five (5) scheduled workdays of excused absences for an illness or pre-planned surgery; however, absences of more than five (5) scheduled workdays for illnesses or pre-planned surgery, must be submitted to and approved by HR. Use of Paid Time Off (PTO) for pre-planned vacations does not require HR approval pursuant to CalOptima Health Policy GA.8018: Paid Time Off (PTO).

D. If an employee requires additional time off work beyond the amount of time authorized herein, and their manager and HR grant a Personal LOA pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence, the Personal LOA will start on the first day after the termination of the LOA granted pursuant to one (1) of the leaves authorized herein.

E. Types of LOA:

1. Bereavement Leave: An employee may take up to three (3) scheduled workdays off with pay [maximum of twenty-four (24) hours] in the event of a death of an employee's: spouse; registered domestic partner; biological, adopted, step or foster child; biological, adopted, step or foster parent; legal guardian; siblings, including step brother and step sister; grandparent; grandchild; parents-in-law; siblings-in-law; or child-in-law. An employee is entitled to take an additional two (2) workdays off as either PTO or unpaid time off [maximum of sixteen (16) hours]. The first five (5) days of paid or unpaid bereavement leave taken in the three (3) months following the death of the family member are considered protected leave. A Bereavement Leave Request Form, available on the InfoNet, must be submitted to HR within thirty (30) calendar days of leave. The employee's manager may approve up to an additional five (5) workdays off

to be taken as either PTO or unpaid time off [maximum of forty (40) hours]. An employee must submit a Leave of Absence Request Form to HR and request a Personal LOA pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence, if the employee plans to take additional PTO or unpaid time off exceeding the additional five (5) scheduled workdays taken as PTO or unpaid time off.

2. Pregnancy Disability Leave (PDL): In accordance with California Pregnancy Regulations, CalOptima Health provides up to four (4) months (calculated based on number of days or hours the employee would normally work within four (4) calendar months) of unpaid PDL per pregnancy to women requiring time off work because of a disability caused by an employee's pregnancy, childbirth, or a related medical condition as described in CalOptima Health Policy GA.8039: Pregnancy Disability Leave of Absence and Lactation Accommodation.

3. Family and Medical Leave Act (FMLA): Under the FMLA, employers must provide eligible employees with up to twelve (12) weeks of unpaid, job-protected leave per rolling twelve (12) month period. In most circumstances, FMLA leave will run at the same time as PDL and/or California Family Rights Act (CFRA) leave (see below), where applicable, and is not in addition to those leaves. FMLA also includes a special leave entitlement for eligible employees to take up to twenty-six (26) weeks of unpaid leave to care for a covered military service member with a qualifying serious injury or illness during a single twelve (12) month period. (See CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence for details.)

4. California Family Rights Act (CFRA) Leave: CFRA provides eligible employees with up to twelve (12) weeks of unpaid, job-protected leave per rolling twelve (12) month period, as detailed in CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence.

5. Military Family Leave: Eligible employees may take an unpaid LOA under FMLA and/or CFRA as described in Sections II.D.3. and 4. of this Policy, to care for a qualified family member or due to a qualifying exigency arising out of the fact that the qualified family member is on covered active duty or has been notified of an impending call or order to active duty.

6. Military Service Leave: The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a Federal law that provides a cumulative of five (5) years of leave (with certain exceptions) and re-employment rights for veterans and members of the National Guard and Reserve following qualifying military service. USERRA requires that a person re-employed under its provisions be given credit for any months they would have been employed but for the military service in determining eligibility for FMLA leave. A person re-employed following military service should be given credit for the period of military service towards the months-of-employment eligibility requirement.

   a. Salary and Compensation for First Thirty (30) Calendar Days for Military Service LOA: Pursuant to Military and Veterans Code, Sections 395.01 and 395.05, an employee may be entitled to their full salary, or compensation, including all appropriate benefits, for the first thirty (30) calendar days of their absence while they are engaged in the performance of ordered duty, active military training, inactive duty training, encampment, naval cruises, special exercises, National Guard active duty, inactive duty training drill periods, or like activity. Pay under this provision is limited to not more than thirty (30) calendar days in any given fiscal year.

   b. A military leave of absence without pay shall be granted to employee members of reserve military units and the National Guard required to perform inactive duty obligations.

Employee may use accrued PTO if sufficient PTO is accrued or may take this time as unpaid.

c. Supplemental Compensation and Continuation of Benefits for Military Service LOA resulting from the National Emergency declared as a Result of the War on Terror: Upon the exhaustion of pay and benefits for the first thirty (30) calendar days, an employee called to active duty or active training duty with the U.S. Armed Forces or National Guard as a result of the National Emergency, may receive supplemental pay in an amount equal to the difference between the amount of the employee's military pay, including any allotments or additional allowances paid to their families, as calculated at the beginning of the employee's leave, and the amount the employee earned as base salary at CalOptima Health in the month prior to the LOA, assuming the amount the employee earned at CalOptima Health is greater than their military pay. The employee is also authorized to receive a continuation of appropriate benefits, including CalOptima Health payment of the employer cost for applicable health insurance premiums for employees and, if applicable, their dependents. In the event the employee's military pay is greater than their CalOptima Health base salary, CalOptima Health will continue the employee's eligible benefits, if elected, and pay for the employee's cost of such benefits without seeking reimbursement. In instances where training or service with the U.S. Armed Forces is not mandatory and is not covered by state, or federal law, the LOA will be unpaid.

7. Military Spouse Leave: Pursuant to Military & Veterans Code, Section 395.10, eligible employees may take up to ten (10) scheduled workdays of unpaid leave when their spouse is on leave from active duty in the U.S. Armed forces, Reserves or National Guard. Employee may use accrued PTO if sufficient PTO is accrued or may take this time as unpaid.

8. Workers' Compensation: In accordance with state law, CalOptima Health provides Workers' Compensation insurance coverage for employees in case of work-related injury or illness. CalOptima Health may grant a LOA subject to any limitations permitted by law for work-related injuries, in accordance with CalOptima Health Policy GA.8041: Workers' Compensation Program.

9. Jury or Witness Duty Leave: Employees may be granted a LOA with regular pay for those hours that coincide with the employee's regularly scheduled working hours for jury duty. CalOptima Health may grant an employee a LOA with pay to appear as a witness in court, other than as a litigant, or to respond to an official order from another governmental jurisdiction for reasons not brought about through the connivance or misconduct of the employee. On days employees are not required to report to court, or on days when the court either dismisses the employee early or requests that the employee report at a later time, whenever practical, the employee must report to work to perform regular duties prior to or after completing jury duty or appearing as a witness, unless the employee's manager approves that the remaining work time is less than reasonable travel time to court and work location. Employees are expected to work with and coordinate with their manager to ensure that their time away from work does not adversely impact business needs, their coworkers, or CalOptima Health members.

10. Parental School Attendance: Pursuant to Labor Code, Section 230.8, employees can take time off up to eight (8) hours in one (1) month or forty (40) hours each year to participate in Child-Related Activities, subject to limitations under applicable laws. ~~-~~Pursuant to Labor Code, Section 230.7, employees can take time off to appear in the school pursuant to a request made under Education Code, Section 48900.1 (Suspension of Pupil~~), subject to limitations under applicable laws.)~~. Accrued PTO shall automatically be used for time-off for Child-Related Activities and/or to appear in a pupil's school, subject to the limitations under applicable laws. Otherwise, the Employee may take this time as unpaid if there is not enough accrued PTO available in accordance with CalOptima Health Policy GA.8018: Paid Time Off (PTO).

11. Victims of Crime or Abuse: Subject to the requirements under Labor Code, sections 230 and 230.1, an employee who is a victim of a crime or abuse, may, with reasonable advance notice, unless the advance notice is not feasible, request a LOA. For purposes of LOA request eligibility, "victim" includes (1) a victim of stalking, domestic violence, or sexual assault; (2) a victim of a crime that caused physical injury or that caused mental injury and a threat of physical injury; and/or (3) a person whose immediate family member is deceased as the direct result of the crime. Employees may elect to use accrued PTO, if available, when a LOA is granted; however, the PTO cannot be used to adjust the start date and will count as part of the LOA. This type of LOA is limited to twelve (12) weeks in a rolling twelve (12) month period. After an employee ~~exhausts their~~reaches PTO ~~accruals~~Exhaustion, if elected, the remaining time off will be unpaid. LOAs under this paragraph may be granted for any of the following:

    a. To seek medical attention for injuries caused by crime or abuse;

    b. To obtain services from a domestic violence shelter, program, rape crisis center, or victim services organization or agency as a result of the crime or abuse;

    c. To obtain psychological counseling or mental health services related to an experience of crime or abuse;

    d. To participate in safety planning and take other actions to increase safety from future crime or abuse, including temporary or permanent relocation; and/or

    e. To obtain or attempt to obtain relief, including, but not limited to, a temporary restraining order, restraining order, or other injunctive relief, to help ensure the health, safety, or welfare of the employee, or their child.

12. Victims of Crime Leave: An employee who is a victim of a crime or whose immediate family member(s) is/are a crime victim may take time off subject to the procedural conditions imposed pursuant to Labor Code, section 230.2, to attend judicial proceedings related to that crime. A copy of the official notice to the victim of each scheduled legal, or judicial, proceeding, or documentation substantiating the employee's attendance at a judicial proceeding is required for this leave. The employee can elect to use accrued PTO for the absence.

13. Volunteer Civil Service Leave: A Civil Service LOA for an unlimited duration may be granted for employees who are required to perform emergency duty as a volunteer firefighter, a reserve police officer, or emergency rescue personnel. An employee who performs duty as a volunteer firefighter, a reserve peace officer, or as emergency rescue personnel is also permitted to take a LOA, not to exceed an aggregate of fourteen (14) scheduled workdays per calendar year for the purpose of fire, law enforcement, or emergency rescue training. LOAs under this paragraph can be unpaid unless the employee elects to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the LOA authorized under this paragraph, and the time covered by the PTO will be counted towards the LOA.

14. Civil Air Patrol Leave: Employees who have been employed for at least ninety (90) calendar days may request a maximum total of ten (10) scheduled workdays per calendar year (three (3) scheduled workdays maximum for a single emergency operational mission, unless otherwise authorized by HR) for Civil Air Patrol duty. LOAs under this paragraph can be unpaid unless the employee elects to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the LOA authorized under this paragraph, and the time covered by the PTO will be counted towards the LOA.

15. LOA as a Reasonable Accommodation: Consistent with the requirements under the Americans with Disabilities Act and the California Fair Employment and Housing Act, subject to a good faith interactive process, CalOptima Health may grant an employee a LOA as a reasonable accommodation, if appropriate.

16. Reproductive Loss Leave: An employee who has worked for CalOptima Health for at least thirty (30) days may take up to five (5) scheduled workdays off following a reproductive loss event ~~(~~. A reproductive loss event means the day of, or for a multiple~~ days), including day~~ event, the final day of a failed adoption, failed surrogacy, miscarriage, stillbirth, or an unsuccessful assisted reproduction. If an employee experiences more than one (1) reproductive loss event within a twelve (12) month period, the employee is ~~only~~ entitled to a total of twenty (20) days of Reproductive Loss Leave within a twelve (12) month period. ~~Eligible employees are~~, and an employee is required to use their accrued Paid Time Off (PTO~~), if available,~~) during their leave. The leave need not be taken on consecutive days or immediately following the reproductive loss event but must be taken within three (3) months of the event triggering the leave. A Leave of Absence Request Form, available on the InfoNet, must be submitted to the HR Department within thirty (30) calendar days of leave. If the desired leave exceeds five (5) workdays per event or twenty (20) days in a twelve (12) month period, an employee may submit for consideration a request for Personal LOA pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence.

17. Administrative Leave: CalOptima Health may place an employee on administrative leave with or without pay pursuant to CalOptima Health Policy GA.8022: Performance and Behavior Standards. (Please refer to this policy for details.)

~~17.~~18. Other Leaves: See CalOptima Health Policy GA.8038: Personal Leave of Absence.

F. Except as required by federal or state law, or as necessary to protect the employee's safety in the workplace, CalOptima Health management and HR shall reasonably maintain the confidentiality, to the extent possible under the circumstances, of any employee requesting time off pursuant to a LOA described herein.

G. To the extent that this policy conflicts with CalOptima Health Policies GA.8038: Personal Leave of Absence, GA.8039: Pregnancy Disability Leave of Absence and Lactation Accommodation, or GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence, those specific policies shall supersede.

III. PROCEDURE

A. Reinstatement: When an employee is placed on a protected LOA, CalOptima Health shall make an effort to hold the employee's position open for the period of the approved leave, with the exception of Personal LOAs in which there is no guarantee of reinstatement. However, to meet business needs, CalOptima Health may need to fill such positions. If an employee's former position is unavailable when the employee returns promptly to work upon the expiration of an approved LOA, CalOptima Health shall make every effort to place the employee in a comparable position for which the employee is qualified. If such a position is not available, the employee will be offered the next suitable position for which the employee is qualified that becomes available. In addition, CalOptima Health will attempt to reasonably accommodate employees who are released for partial or modified duty. An employee who does not accept a position offered by CalOptima Health is considered to have voluntarily terminated employment, effective the day such refusal is made. Employees returning from a LOA related to the employee's own medical condition must obtain a

release to return to work from their health care provider (where applicable) stating that they are able to resume work. CalOptima Health also reserves the right to require employees to participate in a fitness for duty examination at the expense of CalOptima Health prior to return to work.

B. Paid Time Off (PTO) accruals: PTO only accrues during the period an employee is on active duty or utilizing PTO for an approved LOA. Once ~~an employee elects not to use~~ PTO ~~accruals or exhausts~~Exhaustion has been reached within a pay period, all ~~PTO accruals, the~~ remaining time off ~~for~~during an approved LOA shall not be considered time worked for purposes of accruing PTO hours or benefits eligibility.

C. Use of Paid Time Off: An employee is required to use their accrued Paid Time Off (PTO) during an LOA until PTO Exhaustion has been reached (unless deemed otherwise by law, i.e. PDL, receipt of disability benefits, etc.). PTO must be used on consecutive calendar days within each pay period, in accordance with the employee's assigned work schedule, until exhausted. PTO will be applied in increments of no less than one quarter hour (fifteen (15) minutes) when less than a full day of PTO is available. The use of PTO will not adjust the start date of an LOA.

1. If applicable, an employee may make a one (1) time request to coordinate disability benefits with accrued PTO to receive one hundred percent (100%) of their total pay until PTO Exhaustion is reached. Supplemented PTO must be used on consecutive calendar days within each pay period, in accordance with the employee's assigned work schedule, until exhausted.

~~C.~~D. Holidays: If a paid holiday occurs during the period an employee is on a LOA, the employee may be eligible for the holiday pay if PTO is being used for the LOA the day before and the day after the holiday and the holiday pay will be prorated based on the employee's full-time or part-time status as it was in effect prior to the LOA. If a holiday falls on a day in which the employee would have been regularly scheduled to work, the holiday will count against the employee's LOA entitlement. An eligible employee on an approved Personal LOA on December 31 will be eligible to receive a maximum of one (1) Flex Holiday (maximum of eight (8) hours, prorated based on scheduled work hours) upon their return to active status. If the Employee does not return to work after their approved leave of absence, and instead separates from employment with CalOptima Health, the employee will not be eligible to receive the Flex Holiday.

~~D.~~E. Supplemental Compensation: An employee on a Continuous LOA is not eligible to receive certain supplemental compensation, such as Bilingual Pay, Night Shift Premium, Call Back or On Call Pay, Active Certified Case Manager (CCM) Pay, Internet Stipend, Commuter Allowance, or Automobile Allowance~~, or Benefit Income~~ during their LOA. ~~An~~If applicable, an employee on a Continuous LOA may be eligible for Employer-Paid Member Contribution ~~or,~~ Supplemental Retirement Benefit and Benefit Income during any portion of a paid LOA but shall not be eligible if the LOA is unpaid. Executive incentives will be prorated to account for an executive's Personal LOA time period. Executives must be current employees during the pay period the executive incentive is paid out to be eligible to receive the incentive. Continuous LOA is leave that is taken continuously and not broken into separate blocks of time. Supplemental compensation will resume when the employee returns to an active status, and may be prorated, where applicable.

~~E.~~F. Outside employment: Employees may not engage in outside work for other employers, including self-employment, while on an approved LOA from CalOptima Health, unless specifically authorized under this Policy, such as for military service.

~~F.~~G. Documentation: Failure to provide all the required information and/or documentation within the requested or

required timeframe may result in a delay in CalOptima Health's approval of the LOA request, CalOptima Health's denial of the employee's request for a LOA, and/or an impact to the employee's ability to take a LOA as requested.

~~G.~~H. Failure to return promptly: If an employee fails to return to work upon the expiration of an approved LOA and has not submitted required documentation and/or obtained an extension from HR prior to such expiration date, the employee will be considered to have voluntarily resigned. HR will process the employee's voluntary resignation effective three (3) consecutive scheduled workdays following the date the employee failed to return to work, or as soon as reasonably possible given the circumstances. It is the responsibility of the employee to ensure a request for an extended LOA is submitted timely with all required documentation in support of extending the LOA.

~~H.~~I. Misrepresentations: Misrepresenting reasons or information submitted when applying for a LOA may result in corrective action, up to and including termination.

~~Health benefits for~~Status of Employee Benefits during PDL, FMLA, CFRA, Military Service or Workers' Compensation Leaves of Absence: ~~Employer contributions towards an employee's health benefits (medical, vision, and dental) who is~~ An employee on ~~leave~~a LOA pursuant to PDL, FMLA, CFRA, Military Service~~,~~ or Workers' Compensation ~~LOAs,~~ will ~~not continue beyond~~be eligible to receive employer contributions towards their health benefits (medical, vision, and dental). Following the ~~FMLA/CFRA~~ covered period ~~pursuant to~~ of protected leave, employer contributions will only continue while an employee utilizes accrued PTO. After an employee reaches PTO Exhaustion, or has elected not to utilize accrued PTO while receiving disability benefits, CalOptima Health ~~Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence. Employees may elect to purchase continuation of such~~will not pay for group health insurance premiums during any remaining portion of leave. The employee is fully responsible for the employer and employee share of health insurance premiums through a timely election of benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA). In order to ensure continuation of coverage ~~through COBRA. When an employee returns to work, the eligibility and accrual dates for such benefits may be adjusted to reflect~~, an employee must timely pay premiums for the period of the ~~LOA.~~ unpaid LOA and coordinate the payments through CalOptima Health's third-party COBRA administrator. Failure to pay premiums in a timely manner will result in immediate termination of coverage through the remainder of the unpaid LOA. Reinstatement of coverage will occur on the first day of the month following the date the employee returns to work on a part-time or full-time basis. If the employee subsequently returns to an approved LOA, any active benefit coverage will end at the end of the month following the employee's last day worked and PTO Exhaustion.

K. Other benefits: All other benefits not specified herein, provided by CalOptima Health, shall be administered according to HR procedures.

L. Eligibility and Specific Leave Requirements: Refer to specific CalOptima Health policies listed below for detailed information about eligibility and other leave requirements:

~~1.~~2. CalOptima Health Policy GA.8018: Paid Time Off (PTO);

~~2.~~3. CalOptima Health Policy GA.8038: Personal Leave of Absence;

~~3.~~4. CalOptima Health Policy GA.8039: Pregnancy Disability Leave of Absence and Lactation Accommodation;

~~4.~~5. CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence; and/or

~~5.~~6. CalOptima Health Policy GA.8041: Workers' Compensation Program.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Bereavement Leave Request Form
B. California Code, Education Code, §48900.1
C. California Code, Government Code, §12945.1 et seq. (CFRA)
D. California Code, Government Code, §19774-19775 (Military Service Leave)
E. California Code, Labor Code, §230 et seq. (Jury service and other leaves)
F. California Code, Military & Veterans Code, §395.10 (Military Service Leave)
G. CalOptima Health Policy GA.8018: Paid Time Off (PTO)
H. CalOptima Health Policy GA.8022: Performance and Behavior Standards
~~H.~~I. CalOptima Health Policy GA.8038: Personal Leave of Absence
~~I.~~J. CalOptima Health Policy GA.8039: Pregnancy Disability Leave of Absence and Lactation Accommodation
~~J.~~K. CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence
~~K.~~L. CalOptima Health Policy GA.8041: Workers' Compensation Program
~~L.~~M. CalOptima Health Policy GA.8059: Attendance and Timekeeping
~~M.~~N. Leave of Absence Request Form
~~N.~~O. Title 2, California Code of Regulations (C.C.R.), §7291.2 et seq. (Pregnancy Regulations)
~~O.~~P. Title 2, California Code of Regulations (C.C.R.), §7293.5 et seq. (Disability Regulations)
~~P.~~Q. Title 29, Code of Federal Regulations (C.F.R.), Part 825 (FMLA Regulations)
~~Q.~~R. Title 29, United States Code (U.S.C.), §2601 et seq. (FMLA)
~~R.~~S. Title 38, United States Code (U.S.C.), §4301 et seq. (USSERA)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
12/07/2023	Regular Meeting of the CalOptima Health Board of Directors
	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8037	Leave of Absence	Administrative

Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2014	GA.8037	Leave of Absence	Administrative
Revised	05/04/2017	GA.8037	Leave of Absence	Administrative
Revised	08/03/2017	GA.8037	Leave of Absence	Administrative
Revised	09/03/2020	GA.8037	Leave of Absence	Administrative
Revised	12/20/2021	GA.8037	Leave of Absence	Administrative
Revised	05/04/2023	GA.8037	Leave of Absence	Administrative
Revised	12/07/2023	GA.8037	Leave of Absence	Administrative
Revised		GA.8037	Leave of Absence	Administrative

IX. GLOSSARY

Term	Definition
Child-Related Activities	Participation in activities at child's school or day care facility as permitted under Labor Code section 230.8, which includes: finding, enrolling, or reenrolling a child in a school or with a licensed child care provider; child care provider or school, emergency; request for child to be picked up from school/child care or an attendance policy that prohibits the child from attending or requires the child to be picked up from the school or child care provider; behavioral/discipline problems; closure or unexpected unavailability of school (excluding planned holidays); a natural disaster; or to participate in activities of the school or licensed child care provider of their child, if the employee, prior to taking the time off, gives reasonable notice to CalOptima Health.
Continuous Leave of Absence (LOA)	Leave that is taken continuously and not broken into separate blocks of time.
Leave of Absence (LOA)	A term used to describe an authorized period of time off longer than five (5) days that an employee is to be away from their primary job, while maintaining the status of employee.
Paid Time Off (PTO) Exhaustion	Paid Time Off (PTO) will be applied in increments of no less than one quarter hour (fifteen (15) minutes) when less than a full day of PTO is available. When accrued PTO balance is less than one quarter hour (fifteen (15) minutes), PTO is considered to be exhausted with the exception of PTO pay on termination.

Policy:	GA.8037
Title:	**Leave of Absence**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines the general rules and restrictions applicable to a Leave of Absence (LOA).

II. POLICY

A. CalOptima Health shall comply with all applicable state and federal LOA laws and regulations and will implement and administer changes to entitlements as required by law.

B. CalOptima Health will grant a LOA to eligible employees in accordance with CalOptima Health's respective policies and procedures. For leaves specified herein with the exception of Administrative Leave, an employee must submit a Leave of Absence Request Form, available on the InfoNet, to the Human Resources (HR) Department.

C. An employee's manager may approve up to five (5) scheduled workdays of excused absences for an illness or pre-planned surgery; however, absences of more than five (5) scheduled workdays for illnesses or pre-planned surgery, must be submitted to and approved by HR. Use of Paid Time Off (PTO) for pre-planned vacations does not require HR approval pursuant to CalOptima Health Policy GA.8018: Paid Time Off (PTO).

D. If an employee requires additional time off work beyond the amount of time authorized herein, and their manager and HR grant a Personal LOA pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence, the Personal LOA will start on the first day after the termination of the LOA granted pursuant to one (1) of the leaves authorized herein.

E. Types of LOA:

1. Bereavement Leave: An employee may take up to three (3) scheduled workdays off with pay [maximum of twenty-four (24) hours] in the event of a death of an employee's: spouse; registered domestic partner; biological, adopted, step or foster child; biological, adopted, step or foster parent; legal guardian; siblings, including step brother and step sister; grandparent; grandchild; parents-in-law; siblings-in-law; or child-in-law. An employee is entitled to take an additional two (2) workdays off as either PTO or unpaid time off [maximum of sixteen (16) hours]. The first five (5) days of paid or unpaid bereavement leave taken in the three (3) months following the death of the family member are considered protected leave. A Bereavement Leave Request Form, available on the InfoNet, must be submitted to HR within thirty (30) calendar days of leave. The employee's manager may approve up to an additional five (5) workdays off

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to be taken as either PTO or unpaid time off [maximum of forty (40) hours]. An employee must submit a Leave of Absence Request Form to HR and request a Personal LOA pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence, if the employee plans to take additional PTO or unpaid time off exceeding the additional five (5) scheduled workdays taken as PTO or unpaid time off.

2. Pregnancy Disability Leave (PDL): In accordance with California Pregnancy Regulations, CalOptima Health provides up to four (4) months (calculated based on number of days or hours the employee would normally work within four (4) calendar months) of unpaid PDL per pregnancy to women requiring time off work because of a disability caused by an employee's pregnancy, childbirth, or a related medical condition as described in CalOptima Health Policy GA.8039: Pregnancy Disability Leave of Absence and Lactation Accommodation.

3. Family and Medical Leave Act (FMLA): Under the FMLA, employers must provide eligible employees with up to twelve (12) weeks of unpaid, job-protected leave per rolling twelve (12) month period. In most circumstances, FMLA leave will run at the same time as PDL and/or California Family Rights Act (CFRA) leave (see below), where applicable, and is not in addition to those leaves. FMLA also includes a special leave entitlement for eligible employees to take up to twenty-six (26) weeks of unpaid leave to care for a covered military service member with a qualifying serious injury or illness during a single twelve (12) month period. (See CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence for details.)

4. California Family Rights Act (CFRA) Leave: CFRA provides eligible employees with up to twelve (12) weeks of unpaid, job-protected leave per rolling twelve (12) month period, as detailed in CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence.

5. Military Family Leave: Eligible employees may take an unpaid LOA under FMLA and/or CFRA as described in Sections II.D.3. and 4. of this Policy, to care for a qualified family member or due to a qualifying exigency arising out of the fact that the qualified family member is on covered active duty or has been notified of an impending call or order to active duty.

6. Military Service Leave: The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a Federal law that provides a cumulative of five (5) years of leave (with certain exceptions) and re-employment rights for veterans and members of the National Guard and Reserve following qualifying military service. USERRA requires that a person re-employed under its provisions be given credit for any months they would have been employed but for the military service in determining eligibility for FMLA leave. A person re-employed following military service should be given credit for the period of military service towards the months-of-employment eligibility requirement.

   a. Salary and Compensation for First Thirty (30) Calendar Days for Military Service LOA: Pursuant to Military and Veterans Code, Sections 395.01 and 395.05, an employee may be entitled to their full salary, or compensation, including all appropriate benefits, for the first thirty (30) calendar days of their absence while they are engaged in the performance of ordered duty, active military training, inactive duty training, encampment, naval cruises, special exercises, National Guard active duty, inactive duty training drill periods, or like activity. Pay under this provision is limited to not more than thirty (30) calendar days in any given fiscal year.

   b. A military leave of absence without pay shall be granted to employee members of reserve military units and the National Guard required to perform inactive duty obligations.

Employee may use accrued PTO if sufficient PTO is accrued or may take this time as unpaid.

c. Supplemental Compensation and Continuation of Benefits for Military Service LOA resulting from the National Emergency declared as a Result of the War on Terror: Upon the exhaustion of pay and benefits for the first thirty (30) calendar days, an employee called to active duty or active training duty with the U.S. Armed Forces or National Guard as a result of the National Emergency, may receive supplemental pay in an amount equal to the difference between the amount of the employee's military pay, including any allotments or additional allowances paid to their families, as calculated at the beginning of the employee's leave, and the amount the employee earned as base salary at CalOptima Health in the month prior to the LOA, assuming the amount the employee earned at CalOptima Health is greater than their military pay. The employee is also authorized to receive a continuation of appropriate benefits, including CalOptima Health payment of the employer cost for applicable health insurance premiums for employees and, if applicable, their dependents. In the event the employee's military pay is greater than their CalOptima Health base salary, CalOptima Health will continue the employee's eligible benefits, if elected, and pay for the employee's cost of such benefits without seeking reimbursement. In instances where training or service with the U.S. Armed Forces is not mandatory and is not covered by state, or federal law, the LOA will be unpaid.

7. Military Spouse Leave: Pursuant to Military & Veterans Code, Section 395.10, eligible employees may take up to ten (10) scheduled workdays of unpaid leave when their spouse is on leave from active duty in the U.S. Armed forces, Reserves or National Guard. Employee may use accrued PTO if sufficient PTO is accrued or may take this time as unpaid.

8. Workers' Compensation: In accordance with state law, CalOptima Health provides Workers' Compensation insurance coverage for employees in case of work-related injury or illness. CalOptima Health may grant a LOA subject to any limitations permitted by law for work-related injuries, in accordance with CalOptima Health Policy GA.8041: Workers' Compensation Program.

9. Jury or Witness Duty Leave: Employees may be granted a LOA with regular pay for those hours that coincide with the employee's regularly scheduled working hours for jury duty. CalOptima Health may grant an employee a LOA with pay to appear as a witness in court, other than as a litigant, or to respond to an official order from another governmental jurisdiction for reasons not brought about through the connivance or misconduct of the employee. On days employees are not required to report to court, or on days when the court either dismisses the employee early or requests that the employee report at a later time, whenever practical, the employee must report to work to perform regular duties prior to or after completing jury duty or appearing as a witness, unless the employee's manager approves that the remaining work time is less than reasonable travel time to court and work location. Employees are expected to work with and coordinate with their manager to ensure that their time away from work does not adversely impact business needs, their coworkers, or CalOptima Health members.

10. Parental School Attendance: Pursuant to Labor Code, Section 230.8, employees can take time off up to eight (8) hours in one (1) month or forty (40) hours each year to participate in Child-Related Activities, subject to limitations under applicable laws. Pursuant to Labor Code, Section 230.7, employees can take time off to appear in the school pursuant to a request made under Education Code, Section 48900.1 (Suspension of Pupil). Accrued PTO shall automatically be used for time-off for Child-Related Activities and/or to appear in a pupil's school, subject to the limitations under applicable laws. Otherwise, the Employee may take this time as unpaid if there is not enough accrued PTO available in accordance with CalOptima Health Policy GA.8018: Paid Time Off (PTO).

11. Victims of Crime or Abuse: Subject to the requirements under Labor Code, sections 230 and 230.1, an employee who is a victim of a crime or abuse, may, with reasonable advance notice, unless the advance notice is not feasible, request a LOA. For purposes of LOA request eligibility, "victim" includes (1) a victim of stalking, domestic violence, or sexual assault; (2) a victim of a crime that caused physical injury or that caused mental injury and a threat of physical injury; and/or (3) a person whose immediate family member is deceased as the direct result of the crime. Employees may elect to use accrued PTO, if available, when a LOA is granted; however, the PTO cannot be used to adjust the start date and will count as part of the LOA. This type of LOA is limited to twelve (12) weeks in a rolling twelve (12) month period. After an employee reaches PTO Exhaustion, if elected, the remaining time off will be unpaid. LOAs under this paragraph may be granted for any of the following:

    a. To seek medical attention for injuries caused by crime or abuse;

    b. To obtain services from a domestic violence shelter, program, rape crisis center, or victim services organization or agency as a result of the crime or abuse;

    c. To obtain psychological counseling or mental health services related to an experience of crime or abuse;

    d. To participate in safety planning and take other actions to increase safety from future crime or abuse, including temporary or permanent relocation; and/or

    e. To obtain or attempt to obtain relief, including, but not limited to, a temporary restraining order, restraining order, or other injunctive relief, to help ensure the health, safety, or welfare of the employee, or their child.

12. Victims of Crime Leave: An employee who is a victim of a crime or whose immediate family member(s) is/are a crime victim may take time off subject to the procedural conditions imposed pursuant to Labor Code, section 230.2, to attend judicial proceedings related to that crime. A copy of the official notice to the victim of each scheduled legal, or judicial, proceeding, or documentation substantiating the employee's attendance at a judicial proceeding is required for this leave. The employee can elect to use accrued PTO for the absence.

13. Volunteer Civil Service Leave: A Civil Service LOA for an unlimited duration may be granted for employees who are required to perform emergency duty as a volunteer firefighter, a reserve police officer, or emergency rescue personnel. An employee who performs duty as a volunteer firefighter, a reserve peace officer, or as emergency rescue personnel is also permitted to take a LOA, not to exceed an aggregate of fourteen (14) scheduled workdays per calendar year for the purpose of fire, law enforcement, or emergency rescue training. LOAs under this paragraph can be unpaid unless the employee elects to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the LOA authorized under this paragraph, and the time covered by the PTO will be counted towards the LOA.

14. Civil Air Patrol Leave: Employees who have been employed for at least ninety (90) calendar days may request a maximum total of ten (10) scheduled workdays per calendar year (three (3) scheduled workdays maximum for a single emergency operational mission, unless otherwise authorized by HR) for Civil Air Patrol duty. LOAs under this paragraph can be unpaid unless the employee elects to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the LOA authorized under this paragraph, and the time covered by the PTO will be counted towards the LOA.

15. LOA as a Reasonable Accommodation: Consistent with the requirements under the Americans with Disabilities Act and the California Fair Employment and Housing Act, subject to a good faith interactive process, CalOptima Health may grant an employee a LOA as a reasonable accommodation, if appropriate.

16. Reproductive Loss Leave: An employee who has worked for CalOptima Health for at least thirty (30) days may take up to five (5) scheduled workdays off following a reproductive loss event. A reproductive loss event means the day of, or for a multiple day event, the final day of a failed adoption, failed surrogacy, miscarriage, stillbirth, or an unsuccessful assisted reproduction. If an employee experiences more than one (1) reproductive loss event within a twelve (12) month period, the employee is entitled to a total of twenty (20) days of Reproductive Loss Leave within a twelve (12) month period, and an employee is required to use their accrued Paid Time Off (PTO) during their leave. The leave need not be taken on consecutive days or immediately following the reproductive loss event but must be taken within three (3) months of the event triggering the leave. A Leave of Absence Request Form, available on the InfoNet, must be submitted to the HR Department within thirty (30) calendar days of leave. If the desired leave exceeds five (5) workdays per event or twenty (20) days in a twelve (12) month period, an employee may submit for consideration a request for Personal LOA pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence.

17. Administrative Leave: CalOptima Health may place an employee on administrative leave with or without pay pursuant to CalOptima Health Policy GA.8022: Performance and Behavior Standards. (Please refer to this policy for details.)

18. Other Leaves: See CalOptima Health Policy GA.8038: Personal Leave of Absence.

F. Except as required by federal or state law, or as necessary to protect the employee's safety in the workplace, CalOptima Health management and HR shall reasonably maintain the confidentiality, to the extent possible under the circumstances, of any employee requesting time off pursuant to a LOA described herein.

G. To the extent that this policy conflicts with CalOptima Health Policies GA.8038: Personal Leave of Absence, GA.8039: Pregnancy Disability Leave of Absence and Lactation Accommodation, or GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence, those specific policies shall supersede.

III. PROCEDURE

A. Reinstatement: When an employee is placed on a protected LOA, CalOptima Health shall make an effort to hold the employee's position open for the period of the approved leave, with the exception of Personal LOAs in which there is no guarantee of reinstatement. However, to meet business needs, CalOptima Health may need to fill such positions. If an employee's former position is unavailable when the employee returns promptly to work upon the expiration of an approved LOA, CalOptima Health shall make every effort to place the employee in a comparable position for which the employee is qualified. If such a position is not available, the employee will be offered the next suitable position for which the employee is qualified that becomes available. In addition, CalOptima Health will attempt to reasonably accommodate employees who are released for partial or modified duty. An employee who does not accept a position offered by CalOptima Health is considered to have voluntarily terminated employment, effective the day such refusal is made. Employees returning from a LOA related to the employee's own medical condition must obtain a release to return to work from their health care provider (where applicable) stating that they are able

to resume work. CalOptima Health also reserves the right to require employees to participate in a fitness for duty examination at the expense of CalOptima Health prior to return to work.

B. Paid Time Off (PTO) accruals: PTO only accrues during the period an employee is on active duty or utilizing PTO for an approved LOA. Once PTO Exhaustion has been reached within a pay period, all remaining time off during an approved LOA shall not be considered time worked for purposes of accruing PTO hours or benefits eligibility.

C. Use of Paid Time Off: An employee is required to use their accrued Paid Time Off (PTO) during an LOA until PTO Exhaustion has been reached (unless deemed otherwise by law, i.e. PDL, receipt of disability benefits, etc.). PTO must be used on consecutive calendar days within each pay period, in accordance with the employee's assigned work schedule, until exhausted. PTO will be applied in increments of no less than one quarter hour (fifteen (15) minutes) when less than a full day of PTO is available. The use of PTO will not adjust the start date of an LOA.

1. If applicable, an employee may make a one (1) time request to coordinate disability benefits with accrued PTO to receive one hundred percent (100%) of their total pay until PTO Exhaustion is reached. Supplemented PTO must be used on consecutive calendar days within each pay period, in accordance with the employee's assigned work schedule, until exhausted.

D. Holidays: If a paid holiday occurs during the period an employee is on a LOA, the employee may be eligible for the holiday pay if PTO is being used for the LOA the day before and the day after the holiday and the holiday pay will be prorated based on the employee's full-time or part-time status as it was in effect prior to the LOA. If a holiday falls on a day in which the employee would have been regularly scheduled to work, the holiday will count against the employee's LOA entitlement. An eligible employee on an approved Personal LOA on December 31 will be eligible to receive a maximum of one (1) Flex Holiday (maximum of eight (8) hours, prorated based on scheduled work hours) upon their return to active status. If the Employee does not return to work after their approved leave of absence, and instead separates from employment with CalOptima Health, the employee will not be eligible to receive the Flex Holiday.

E. Supplemental Compensation: An employee on a Continuous LOA is not eligible to receive certain supplemental compensation, such as Bilingual Pay, Night Shift Premium, Call Back or On Call Pay, Active Certified Case Manager (CCM) Pay, Internet Stipend, Commuter Allowance, or Automobile Allowance during their LOA. If applicable, an employee on a Continuous LOA may be eligible for Employer-Paid Member Contribution, Supplemental Retirement Benefit and Benefit Income during any portion of a paid LOA but shall not be eligible if the LOA is unpaid. Executive incentives will be prorated to account for an executive's Personal LOA time period. Executives must be current employees during the pay period the executive incentive is paid out to be eligible to receive the incentive. Continuous LOA is leave that is taken continuously and not broken into separate blocks of time. Supplemental compensation will resume when the employee returns to an active status, and may be prorated, where applicable.

F. Outside employment: Employees may not engage in outside work for other employers, including self-employment, while on an approved LOA from CalOptima Health, unless specifically authorized under this Policy, such as for military service.

G. Documentation: Failure to provide all the required information and/or documentation within the requested or required timeframe may result in a delay in CalOptima Health's approval of the LOA request, CalOptima Health's denial of the employee's request for a LOA, and/or an impact to the employee's ability to take a LOA as requested.

H. Failure to return promptly: If an employee fails to return to work upon the expiration of an approved LOA and has not submitted required documentation and/or obtained an extension from HR prior to

such expiration date, the employee will be considered to have voluntarily resigned. HR will process the employee's voluntary resignation effective three (3) consecutive scheduled workdays following the date the employee failed to return to work, or as soon as reasonably possible given the circumstances. It is the responsibility of the employee to ensure a request for an extended LOA is submitted timely with all required documentation in support of extending the LOA.

I. Misrepresentations: Misrepresenting reasons or information submitted when applying for a LOA may result in corrective action, up to and including termination.

Status of Employee Benefits during PDL, FMLA, CFRA, Military Service or Workers' Compensation Leaves of Absence: An employee on a LOA pursuant to PDL, FMLA, CFRA, Military Service or Workers' Compensation will be eligible to receive employer contributions towards their health benefits (medical, vision, and dental). Following the covered period of protected leave, employer contributions will only continue while an employee utilizes accrued PTO. After an employee reaches PTO Exhaustion or has elected not to utilize accrued PTO while receiving disability benefits, CalOptima Health will not pay for group health insurance premiums during any remaining portion of leave. The employee is fully responsible for the employer and employee share of health insurance premiums through a timely election of benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA). In order to ensure continuation of coverage, an employee must timely pay premiums for the period of the unpaid LOA and coordinate the payments through CalOptima Health's third-party COBRA administrator. Failure to pay premiums in a timely manner will result in immediate termination of coverage through the remainder of the unpaid LOA. Reinstatement of coverage will occur on the first day of the month following the date the employee returns to work on a part-time or full-time basis. If the employee subsequently returns to an approved LOA, any active benefit coverage will end at the end of the month following the employee's last day worked and PTO Exhaustion.

K. Other benefits: All other benefits not specified herein, provided by CalOptima Health, shall be administered according to HR procedures.

L. Eligibility and Specific Leave Requirements: Refer to specific CalOptima Health policies listed below for detailed information about eligibility and other leave requirements:

2. CalOptima Health Policy GA.8018: Paid Time Off (PTO);

3. CalOptima Health Policy GA.8038: Personal Leave of Absence;

4. CalOptima Health Policy GA.8039: Pregnancy Disability Leave of Absence and Lactation Accommodation;

5. CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence; and/or

6. CalOptima Health Policy GA.8041: Workers' Compensation Program.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Bereavement Leave Request Form
B. California Code, Education Code, §48900.1
C. California Code, Government Code, §12945.1 et seq. (CFRA)

D. California Code, Government Code, §19774-19775 (Military Service Leave)
E. California Code, Labor Code, §230 et seq. (Jury service and other leaves)
F. California Code, Military & Veterans Code, §395.10 (Military Service Leave)
G. CalOptima Health Policy GA.8018: Paid Time Off (PTO)
H. CalOptima Health Policy GA.8022: Performance and Behavior Standards
I. CalOptima Health Policy GA.8038: Personal Leave of Absence
J. CalOptima Health Policy GA.8039: Pregnancy Disability Leave of Absence and Lactation Accommodation
K. CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence
L. CalOptima Health Policy GA.8041: Workers' Compensation Program
M. CalOptima Health Policy GA.8059: Attendance and Timekeeping
N. Leave of Absence Request Form
O. Title 2, California Code of Regulations (C.C.R.), §7291.2 et seq. (Pregnancy Regulations)
P. Title 2, California Code of Regulations (C.C.R.), §7293.5 et seq. (Disability Regulations)
Q. Title 29, Code of Federal Regulations (C.F.R.), Part 825 (FMLA Regulations)
R. Title 29, United States Code (U.S.C.), §2601 et seq. (FMLA)
S. Title 38, United States Code (U.S.C.), §4301 et seq. (USSERA)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
12/07/2023	Regular Meeting of the CalOptima Health Board of Directors
	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8037	Leave of Absence	Administrative
Revised	02/01/2014	GA.8037	Leave of Absence	Administrative
Revised	05/04/2017	GA.8037	Leave of Absence	Administrative
Revised	08/03/2017	GA.8037	Leave of Absence	Administrative
Revised	09/03/2020	GA.8037	Leave of Absence	Administrative
Revised	12/20/2021	GA.8037	Leave of Absence	Administrative
Revised	05/04/2023	GA.8037	Leave of Absence	Administrative
Revised	12/07/2023	GA.8037	Leave of Absence	Administrative
Revised		GA.8037	Leave of Absence	Administrative

IX. GLOSSARY

Term	Definition
Child-Related Activities	Participation in activities at child's school or day care facility as permitted under Labor Code section 230.8, which includes: finding, enrolling, or reenrolling a child in a school or with a licensed child care provider; child care provider or school, emergency; request for child to be picked up from school/child care or an attendance policy that prohibits the child from attending or requires the child to be picked up from the school or child care provider; behavioral/discipline problems; closure or unexpected unavailability of school (excluding planned holidays); a natural disaster; or to participate in activities of the school or licensed child care provider of their child, if the employee, prior to taking the time off, gives reasonable notice to CalOptima Health.
Continuous Leave of Absence (LOA)	Leave that is taken continuously and not broken into separate blocks of time.
Leave of Absence (LOA)	A term used to describe an authorized period of time off longer than five (5) days that an employee is to be away from their primary job, while maintaining the status of employee.
Paid Time Off (PTO) Exhaustion	Paid Time Off (PTO) will be applied in increments of no less than one quarter hour (fifteen (15) minutes) when less than a full day of PTO is available. When accrued PTO balance is less than one quarter hour (fifteen (15) minutes), PTO is considered to be exhausted with the exception of PTO pay on termination.

Policy:	GA.8040
Title:	**Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	12/05/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines the Leave of Absence (LOA) protocols for employees eligible under the Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA).

II. POLICY

A. Eligibility: All full-time and part-time employees employed by CalOptima Health for a total of at least twelve (12) months and with at least one thousand two hundred fifty (1,250) hours of service for CalOptima Health in the prior twelve (12) months as of the first date of the requested leave are eligible for an FMLA and/or CFRA leave.

1. If the leave is for FMLA only, the twelve (12) months need not be consecutive, provided that the employee has not had a break in service from the employer for a period of seven (7) years or more. If an employee has had a break of seven (7) years or more, time prior to the break will not be counted towards eligibility.

B. General provisions: -An eligible employee may take an unpaid leave of absence under the FMLA and CFRA for the following reasons:

1. Baby bonding: -The birth of a Child of the employee and to care for the newborn Child;

2. Placement of Child: -The placement of a Child with an employee for adoption or foster care.

3. Family care: To care for the employee's Spouse, Child (regardless of age or dependency status), or Parent, who has a serious health condition. -In addition to the list of eligible family members above, under CFRA, the definition of family is expanded to include employee's Registered Domestic Partner, grandparent, grandchild, sibling, or Designated Person. Employees are limited to one Designated Person in a twelve (12) month period.

4. Medical leave: -For the employee's own serious health condition (including work-related injury or illness) that makes them unable to work at all, or unable to perform the functions of their job. While an employee disabled by pregnancy, childbirth, or related medical condition may qualify for a LOA under FMLA, such conditions do not qualify the employee for a LOA under CFRA.

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5. Leave for a Qualifying Exigency: -Qualifying Exigencies may arise when an employee's Spouse, Registered Domestic Partner, Child, or Parent who is a covered military service member on active duty has been notified of an impending call or order to covered active duty.

6. Covered service members (Military): -To care for a covered military service member with a qualifying serious injury or illness if the employee is the Spouse, Registered Domestic Partner, Child, Parent or next of kin of the military service member. -CalOptima Health may approve a LOA for an employee of up to twenty-six (26) work weeks, during a single twelve (12) month period, to care for a covered military service member with a qualifying serious injury or illness (up to twelve (12) work weeks covered under CFRA).

C. Computation of Time:- Unless otherwise specified, an eligible employee is entitled to take up to twelve (12) workweeks of leave during a rolling twelve (12) month period measured backward from the date an employee uses any FMLA and/or CFRA leave. -Such leave may be taken on a continuous, intermittent, or reduced schedule when medically necessary. -An employee should schedule an intermittent leave, in cooperation with management to minimize disruption at the workplace. -The basic minimum duration of the leave for baby bonding or placement of a Child under the CFRA shall be two (2) work weeks; provided, however, CalOptima Health will grant a request for CFRA leave of less than two (2) work weeks' duration on any two (2) occasions. In most circumstances, FMLA leave will run at the same time as CFRA leave. -However, there may be other circumstances where an employee may exhaust one type of leave, but not the other, depending on the eligibility criteria and purpose of the leave. -For example, if the employee is disabled by pregnancy, childbirth, or related medical condition, FMLA runs concurrently with Pregnancy Disability Leave (PDL) and may run concurrently with CFRA if less than twelve (12) work weeks of PDL are taken.

D. Pregnancy Disability Leave: -An employee disabled by pregnancy, childbirth, or related medical condition, may take a PDL, which runs concurrently with FMLA leave, and may thereafter qualify for a CFRA leave in addition to the time used for the PDL. -Disabilities due to pregnancy, childbirth, or related medical condition are not covered by CFRA as a covered medical condition. The following example demonstrates how the three (3) protected leaves work together.- The assumption in this scenario is that the employee is disabled due to pregnancy or childbirth for the entire seventeen (17) work weeks and three (3) days that are permitted.

E. Exhaustion of Leave: -An employee may be eligible to take a Personal LOA following exhaustion of their FMLA or CFRA LOA in accordance with CalOptima Health Policy GA.8038: Personal Leave of Absence. -CalOptima Health may engage in the interactive process with an employee who has exhausted their leave under FMLA and/or CFRA, if applicable, and requires additional time off due to the employee's qualifying disability.

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F. Use of Paid Time Off: ~~-~~An employee is required to use their accrued Paid Time Off (PTO) during their FMLA or CFRA leave until PTO Exhaustion has been reached (unless deemed otherwise by law, i.e., PDL, receipt of disability ~~benefit~~benefits, etc.). ~~An employee may request to use accrued PTO during PDL or to coordinate~~ PTO must be used on consecutive calendar days within each pay period, in accordance with ~~disability benefits, if applicable, to supplement an employee's income, up to one hundred percent (100%) of the employee's total pay. However, the use of such~~the employee's assigned work schedule, until exhausted. PTO will be applied in increments of no less than one quarter hour (fifteen (15) minutes) when less than a full day of PTO is available. The use of PTO will not adjust the start date of the LOA. ~~-~~The time covered by PTO will still count as part of the LOA. ~~-~~Once ~~all~~ PTO ~~accruals have~~Exhaustion has been ~~exhausted~~reached, all remaining time off shall be without pay.

1. If applicable, an employee may make a one (1) time request to coordinate disability benefits with accrued PTO to receive one hundred percent (100%) of their total pay until PTO Exhaustion is reached. Supplemented PTO must be used on consecutive calendar days within each pay period, in accordance with the employee's assigned work schedule, until exhausted.

G. Certification:~~-~~ Employees requesting LOA under the FMLA and/or CFRA are required to provide a healthcare provider's certificate that verifies the serious health condition of the employee, employee's Child (regardless of age or dependency status~~-~~), Parent,~~ or~~ Spouse, Registered Domestic Partner, grandparent, grandchild, sibling, or Designated Person, including a covered ~~service member~~servicemember, which satisfies the requirements of FMLA and/or CFRA, as applicable, and outlines the anticipated duration of the leave. Certification must be provided within fifteen (15) calendar days from the proposed leave start date. ~~-~~Employees requesting LOA under CFRA that is unrelated to serious health conditions, such as the qualified baby bonding time off, do not need to submit healthcare provider certification, but will be required to submit proof of birth, adoption or foster care placement documentation. ~~-~~Employees requesting LOA under FMLA for leave because of a Qualifying Exigency must provide complete and sufficient certification in support of the request for FMLA, including, but not limited to, written documentation confirming a military member's covered active duty or call to covered active-duty status.

H. Appointments: ~~-~~Employees must make every attempt to schedule doctor's visits or other medical appointments as not to unduly disrupt business operations.

I. Health Benefits:

1. Continuation of Health Benefits: ~~CalOptima Health~~An employee on a FMLA and/or CFRA LOA pursuant to this policy will ~~continue to pay the employer's portion of employee's~~be eligible to receive employer contributions towards their health ~~insurance premium~~benefits (medical, vision, and dental) at the same level and under the same conditions as coverage would have been if the employee was working during the entire FMLA and/or CFRA LOA period, which may be up to twelve (12) workweeks (unless employee also takes PDL in which case the employee will be entitled to continued benefits during the entire period of PDL and CFRA) or up to twenty-six (26) workweeks during a leave to care for a covered military service member with a qualifying serious injury or illness.

2. Deductions:~~-~~ While an employee is receiving a CalOptima Health payroll check because they are exhausting their accrued PTO benefits, the employee's health benefits and other insurance premiums will continue to be deducted from their paycheck at the active employee rate. ~~-~~These benefits include medical, dental, vision, and any elected voluntary benefits.

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3. Continuation of Coverage.- When an employee is no longer receiving a paycheck or the amount is not sufficient to cover the employee's portion of the health insurance premium costs, the employee must continue to timely pay their portion of the health insurance premium at the active employee rate for the duration of the FMLA and/or CFRA LOA, by the first (1st) of the month for that month's benefit coverage. -The employee should arrange the method of payment with Human Resources (HR) as soon as it is anticipated that their pay will be insufficient to cover their share of the cost. The first (1st) payment may include any portion of the previous month's premium that was not paid through payroll deduction. ~~If an employee remains on a Personal LOA after exhausting FMLA and/or CFRA, the employee must pay the employer and employee share of health insurance premium consistent with CalOptima Health Policy GA.8038: Personal Leave of Absence.~~

4. Timely payment of Premiums. The employee is responsible for ensuring timely payment of health benefit premiums. ~~If payment~~Payment that is more than thirty (30) calendar days late~~, insurance~~ will result in the immediate termination of coverage ~~for unpaid months will be canceled.~~ through the remainder of the LOA.

5. Reinstatement of Benefits. Upon return to active full or part-time employment, regardless of whether the employee's coverage was terminated for failure to pay premiums due, coverage for health benefits, other benefits, and payroll deductions will be reinstated ~~without processing an Evidence of Insurance (EOI), and the pre-existing clause will not be applicable to conditions treated during the LOA.~~ . . Health and other benefits will be reinstated on the first (1st) day of the month following the employee's return to work. Past due premiums owed prior to the termination of coverage will be deducted on the next payroll deduction upon employee's express written consent. If the employee subsequently returns to an approved LOA, any active benefit coverage will end at the end of the month following the employee's last day worked and PTO Exhaustion.

6. Recovery of premiums.- CalOptima Health reserves the right to recover from the employee, the entire premium paid by CalOptima Health, required to maintain employee coverage while the employee was on FMLA and/or CFRA LOA, in the event the employee fails to return from an approved LOA; or if the conditions described pursuant to the applicable law occurs entitling the employer to recover the premium that the employer paid.

7. Benefits upon FMLA and/or CFRA Exhaustion: If an employee remains on a Personal LOA after exhausting FMLA and/or CFRA, employer contributions will only continue while an employee utilizes accrued PTO consistent with CalOptima Health Policy GA.8038: Personal Leave of Absence. After an employee reaches PTO Exhaustion or has elected not to utilize accrued PTO while receiving disability benefits or due to PDL, CalOptima Health will not pay for group health insurance premiums during any remaining portion of leave. The employee is fully responsible for the employer and employee share of health insurance premiums through a timely election of benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA). In order to ensure continuation of coverage, an employee must timely pay premiums for the period of the unpaid LOA and coordinate the payments through CalOptima Health's third-party COBRA administrator.

J. Returning to Work:- Employees returning from a LOA arising from the employee's own serious health condition must obtain a release to return to work from their health care provider stating that they are able to resume work. -Where applicable, if an employee has a qualifying disability under the Americans with Disabilities Act (ADA), the employee is responsible for timely requesting a reasonable accommodation, if needed, providing sufficient medical documentation in support of their needs for a reasonable accommodation, and engaging in the interactive process. Employees do

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not have to provide a doctor's certification when returning from baby bonding or other qualified leaves specified under FMLA and/or CFRA. -Except in very limited circumstances, an employee who exercises their right to take FMLA and/or CFRA leave has a right to reinstatement to the same or comparable position, pursuant to the conditions, restrictions and exceptions outlined under the FMLA and CFRA laws.

III. PROCEDURE

Responsible Party	Action
Employee	1. Request an LOA designating FMLA and/or CFRA at least thirty (30) calendar days in advance, where practicable, by completing the Leave of Absence Request Form available on the InfoNet and submitting it to HR. 2. When applicable, provide a certification by the health care provider meeting the requirements under FMLA and/or CFRA, as applicable, that verifies the serious health condition of the employee, employee's Spouse, Registered Domestic Partner, Child, (regardless of age or dependency status,), Parent, grandparent, grandchild, sibling or Designated Person, including a covered service member, and outlines the anticipated duration of the leave. 3. Initiate contact with HR regarding continuation of benefits, use of PTO, where applicable, and any required payment arrangements. 4. Maintain regular communication with HR regarding the leave status and expected return to work. 5. If applicable, continue to timely pay employee share of health insurance premiums while on approved FMLA and/or CFRA to HR. 6. If ~~personal~~Personal LOA continues after approved FMLA and/or CFRA period has been exhausted and still receiving a CalOptima Health payroll check, continue to timely pay the ~~employer and~~ employee share of health insurance premiums to HR. 7. If Personal LOA continues after approved FMLA and/or CFRA period has been exhausted and no longer in active status, enroll in COBRA and make timely payments to CalOptima Health's third-party administrator. ~~7.~~8. Provide the required documentation to return to work, with or without a reasonable accommodation, on the agreed upon date.

Responsible Party	Action
Human Resources (HR)	1. Ensure that all required notices pursuant to FMLA and CFRA are posted and disseminated as required by law (General Notice). 2. Upon receipt of a request by employee for FMLA and/or CFRA leave, or upon knowledge that an employee's leave may be for an FMLA/CFRA-qualifying reason, notify the employee of the employee's eligibility to take FMLA/CFRA leave **within five (5) business days,** absent extenuating circumstances (Rights and Responsibilities Notice). -If the employee is not eligible for FMLA/CFRA leave, state at least one (1) reason why the employee is not eligible. 3. Designate leave as FMLA/CFRA qualifying and give notice of the designation to the employee **within five (5) business days**, absent extenuating circumstances (Designation Notice). 4. If applicable, ensure that required documentation (i.e., medical certification for serious health condition) has been submitted and has been completed thoroughly by the employee and/or health care provider. 5. Manage and process the LOA request, including any requested leave extensions or change to intermittent or reduced work schedule. 6. Help the employee with a plan to transition back to work, when applicable. 7. Engage in an interactive process with the employee, where applicable.
Supervisor and/or Manager	1. Notify HR upon knowledge that an employee may need to take a FMLA and/or CFRA-qualifying leave of absence, including intermittent leave or leave on a reduced schedule (for example, employee is hospitalized, employee requests time off to care for a sick Parent or Child or for baby-bonding purposes, etc.). 2. Notify HR if an employee provides a return-to-work status update.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.8018: Paid Time Off (PTO)
B. CalOptima Health Policy GA.8037: Leave of Absence
C. CalOptima Health Policy GA.8038: Personal Leave of Absence
D. CalOptima Health Policy GA.8039: Pregnancy Disability Leave ~~of Absence~~ and ~~Lactation~~Related Workplace Accommodation
E. CalOptima Health Policy GA.8041: Workers' Compensation ~~Leave of Absence~~Program
F. Government Code § 12945.2 *et seq*. (CFRA)

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G. Leave of Absence Request Form
H. Title 2, California Code of Regulations § 11035 *et. seq*. (Pregnancy Regulations)
I. Title 2, California Code of Regulations § 11087 *et seq*. (CFRA Regulations)
J. Title 29, Code of Federal Regulations (C.F.R.) Part 825 *et seq*. (FMLA Regulations)
K. Title 29, United States Code section 2601 *et seq*. (FMLA)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act(CFRA) Leaves of Absence	Administrative
Revised	08/07/2014	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence	Administrative
Revised	06/07/2018	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence	Administrative
Revised	12/20/2021	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence	Administrative
Revised	05/04/2023	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence	Administrative
Revised	12/05/2024	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence	Administrative

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IX. GLOSSARY

Term	Definition
Child	The biological, adopted, foster, or ~~step child~~stepchild, legal ward, or a child of a person standing in loco parentis who is under 18 years of age. A person is in loco parentis to a child if he or she assumes parental status and discharges parental duties. The California Family Rights Act (CFRA) also includes a child of any age and a child of an employee's Registered Domestic Partner.
Designated Person	A term used to describe an individual related to the employee by blood or whose association with the employee is equivalent to a family relationship.
Leave of Absence (LOA)	A term used to describe an authorized period of time off longer than five (5) days that an employee is to be away from their primary job, while maintaining the status of employee.
Paid Time Off (PTO) Exhaustion	Paid Time Off (PTO) will be applied in increments of no less than one quarter hour (fifteen (15) minutes) when less than a full day of PTO is available. When accrued PTO balance is less than one quarter hour (fifteen (15) minutes), PTO is considered to be exhausted with the exception of PTO pay on termination.
Parent	The biological, adoptive, step or foster parent of an employee or an individual who stands or stood in loco parentis to an employee when the employee was a child. The California Family Rights Act (CFRA) also includes parents-in-law.
Qualifying Exigency	The military leave entitlement helps families of military service members manage their affairs while a covered military service member is on active duty or called to covered active duty status (or has been notified of an impending call or order to covered active duty). -According to the FMLA, 29 C.F.R. section 825.126, a Qualifying Exigency could include the following: 1. Short-notice deployment; 2. Military events and related activities; 3. Childcare and school activities; 4. Financial and legal arrangements; 5. Counseling; 6. Rest and recuperation; 7. Post-deployment activities; 8. Parental care; or 9. Additional activities not encompassed in the other categories but agreed to by the employer and employee.
Registered Domestic Partner	Registered domestic partners can be any couples, regardless of their sex. Only domestic partners who have registered with the State of California – or who formed a substantially equivalent legal union in another jurisdiction – qualify as Registered Domestic Partners.
Spouse	Defined as a husband or a wife. For purposes of this definition, husband or wife refers to the other person with whom an individual entered into marriage as defined or recognized under state law for purposes of marriage in the State in which the marriage was entered into (often referred to as "the place of celebration"). This definition includes individuals in same sex or common law marriages.

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Policy:	GA.8040
Title:	**Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	12/05/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines the Leave of Absence (LOA) protocols for employees eligible under the Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA).

II. POLICY

A. Eligibility: All full-time and part-time employees employed by CalOptima Health for a total of at least twelve (12) months and with at least one thousand two hundred fifty (1,250) hours of service for CalOptima Health in the prior twelve (12) months as of the first date of the requested leave are eligible for an FMLA and/or CFRA leave.

1. If the leave is for FMLA only, the twelve (12) months need not be consecutive, provided that the employee has not had a break in service from the employer for a period of seven (7) years or more. If an employee has had a break of seven (7) years or more, time prior to the break will not be counted towards eligibility.

B. General provisions: An eligible employee may take an unpaid leave of absence under the FMLA and CFRA for the following reasons:

1. Baby bonding: The birth of a Child of the employee and to care for the newborn Child;

2. Placement of Child: The placement of a Child with an employee for adoption or foster care.

3. Family care: To care for the employee's Spouse, Child (regardless of age or dependency status), or Parent, who has a serious health condition. In addition to the list of eligible family members above, under CFRA, the definition of family is expanded to include employee's Registered Domestic Partner, grandparent, grandchild, sibling, or Designated Person. Employees are limited to one Designated Person in a twelve (12) month period.

4. Medical leave: For the employee's own serious health condition (including work-related injury or illness) that makes them unable to work at all, or unable to perform the functions of their job. While an employee disabled by pregnancy, childbirth, or related medical condition may qualify for a LOA under FMLA, such conditions do not qualify the employee for a LOA under CFRA.

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5. Leave for a Qualifying Exigency: Qualifying Exigencies may arise when an employee's Spouse, Registered Domestic Partner, Child, or Parent who is a covered military service member on active duty has been notified of an impending call or order to covered active duty.

6. Covered service members (Military): To care for a covered military service member with a qualifying serious injury or illness if the employee is the Spouse, Registered Domestic Partner, Child, Parent or next of kin of the military service member. CalOptima Health may approve a LOA for an employee of up to twenty-six (26) work weeks, during a single twelve (12) month period, to care for a covered military service member with a qualifying serious injury or illness (up to twelve (12) work weeks covered under CFRA).

C. Computation of Time: Unless otherwise specified, an eligible employee is entitled to take up to twelve (12) workweeks of leave during a rolling twelve (12) month period measured backward from the date an employee uses any FMLA and/or CFRA leave. Such leave may be taken on a continuous, intermittent, or reduced schedule when medically necessary. An employee should schedule an intermittent leave, in cooperation with management to minimize disruption at the workplace. The basic minimum duration of the leave for baby bonding or placement of a Child under the CFRA shall be two (2) work weeks; provided, however, CalOptima Health will grant a request for CFRA leave of less than two (2) work weeks' duration on any two (2) occasions. In most circumstances, FMLA leave will run at the same time as CFRA leave. However, there may be other circumstances where an employee may exhaust one type of leave, but not the other, depending on the eligibility criteria and purpose of the leave. For example, if the employee is disabled by pregnancy, childbirth, or related medical condition, FMLA runs concurrently with Pregnancy Disability Leave (PDL) and may run concurrently with CFRA if less than twelve (12) work weeks of PDL are taken.

D. Pregnancy Disability Leave: An employee disabled by pregnancy, childbirth, or related medical condition, may take a PDL, which runs concurrently with FMLA leave, and may thereafter qualify for a CFRA leave in addition to the time used for the PDL. Disabilities due to pregnancy, childbirth, or related medical condition are not covered by CFRA as a covered medical condition. The following example demonstrates how the three (3) protected leaves work together. The assumption in this scenario is that the employee is disabled due to pregnancy or childbirth for the entire seventeen (17) work weeks and three (3) days that are permitted.

E. Exhaustion of Leave: An employee may be eligible to take a Personal LOA following exhaustion of their FMLA or CFRA LOA in accordance with CalOptima Health Policy GA.8038: Personal Leave of Absence. CalOptima Health may engage in the interactive process with an employee who has exhausted their leave under FMLA and/or CFRA, if applicable, and requires additional time off due to the employee's qualifying disability.

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F. Use of Paid Time Off: An employee is required to use their accrued Paid Time Off (PTO) during their FMLA or CFRA leave until PTO Exhaustion has been reached (unless deemed otherwise by law, i.e., PDL, receipt of disability benefits, etc.). PTO must be used on consecutive calendar days within each pay period, in accordance with the employee's assigned work schedule, until exhausted. PTO will be applied in increments of no less than one quarter hour (fifteen (15) minutes) when less than a full day of PTO is available. The use of PTO will not adjust the start date of the LOA. The time covered by PTO will still count as part of the LOA. Once PTO Exhaustion has been reached, all remaining time off shall be without pay.

1. If applicable, an employee may make a one (1) time request to coordinate disability benefits with accrued PTO to receive one hundred percent (100%) of their total pay until PTO Exhaustion is reached. Supplemented PTO must be used on consecutive calendar days within each pay period, in accordance with the employee's assigned work schedule, until exhausted.

G. Certification: Employees requesting LOA under the FMLA and/or CFRA are required to provide a healthcare provider's certificate that verifies the serious health condition of the employee, employee's Child (regardless of age or dependency status), Parent, Spouse, Registered Domestic Partner, grandparent, grandchild, sibling, or Designated Person, including a covered servicemember, which satisfies the requirements of FMLA and/or CFRA, as applicable, and outlines the anticipated duration of the leave. Certification must be provided within fifteen (15) calendar days from the proposed leave start date. Employees requesting LOA under CFRA that is unrelated to serious health conditions, such as the qualified baby bonding time off, do not need to submit healthcare provider certification, but will be required to submit proof of birth, adoption or foster care placement documentation. Employees requesting LOA under FMLA for leave because of a Qualifying Exigency must provide complete and sufficient certification in support of the request for FMLA, including, but not limited to, written documentation confirming a military member's covered active duty or call to covered active-duty status.

H. Appointments: Employees must make every attempt to schedule doctor's visits or other medical appointments as not to unduly disrupt business operations.

I. Health Benefits:

1. Continuation of Health Benefits: An employee on a FMLA and/or CFRA LOA pursuant to this policy will be eligible to receive employer contributions towards their health benefits (medical, vision, and dental) at the same level and under the same conditions as coverage would have been if the employee was working during the entire FMLA and/or CFRA LOA period, which may be up to twelve (12) workweeks (unless employee also takes PDL in which case the employee will be entitled to continued benefits during the entire period of PDL and CFRA) or up to twenty-six (26) workweeks during a leave to care for a covered military service member with a qualifying serious injury or illness.

2. Deductions: While an employee is receiving a CalOptima Health payroll check because they are exhausting their accrued PTO benefits, the employee's health benefits and other insurance premiums will continue to be deducted from their paycheck at the active employee rate. These benefits include medical, dental, vision, and any elected voluntary benefits.

3. Continuation of Coverage. When an employee is no longer receiving a paycheck or the amount is not sufficient to cover the employee's portion of the health insurance premium costs, the employee must continue to timely pay their portion of the health insurance premium at the active employee rate for the duration of the FMLA and/or CFRA LOA, by the first (1st) of the month for that month's benefit coverage. The employee should arrange the method of payment

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with Human Resources (HR) as soon as it is anticipated that their pay will be insufficient to cover their share of the cost. The first (1st) payment may include any portion of the previous month's premium that was not paid through payroll deduction.

4. Timely payment of Premiums. The employee is responsible for ensuring timely payment of health benefit premiums. Payment that is more than thirty (30) calendar days late will result in the immediate termination of coverage through the remainder of the LOA.

5. Reinstatement of Benefits. Upon return to active full or part-time employment, regardless of whether the employee's coverage was terminated for failure to pay premiums due, coverage for health benefits, other benefits, and payroll deductions will be reinstated. . Health and other benefits will be reinstated on the first (1st) day of the month following the employee's return to work. Past due premiums owed prior to the termination of coverage will be deducted on the next payroll deduction upon employee's express written consent. If the employee subsequently returns to an approved LOA, any active benefit coverage will end at the end of the month following the employee's last day worked and PTO Exhaustion.

6. Recovery of premiums. CalOptima Health reserves the right to recover from the employee, the entire premium paid by CalOptima Health, required to maintain employee coverage while the employee was on FMLA and/or CFRA LOA, in the event the employee fails to return from an approved LOA; or if the conditions described pursuant to the applicable law occurs entitling the employer to recover the premium that the employer paid.

7. Benefits upon FMLA and/or CFRA Exhaustion: If an employee remains on a Personal LOA after exhausting FMLA and/or CFRA, employer contributions will only continue while an employee utilizes accrued PTO consistent with CalOptima Health Policy GA.8038: Personal Leave of Absence. After an employee reaches PTO Exhaustion or has elected not to utilize accrued PTO while receiving disability benefits or due to PDL, CalOptima Health will not pay for group health insurance premiums during any remaining portion of leave. The employee is fully responsible for the employer and employee share of health insurance premiums through a timely election of benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA). In order to ensure continuation of coverage, an employee must timely pay premiums for the period of the unpaid LOA and coordinate the payments through CalOptima Health's third-party COBRA administrator.

J. Returning to Work: Employees returning from a LOA arising from the employee's own serious health condition must obtain a release to return to work from their health care provider stating that they are able to resume work. Where applicable, if an employee has a qualifying disability under the Americans with Disabilities Act (ADA), the employee is responsible for timely requesting a reasonable accommodation, if needed, providing sufficient medical documentation in support of their needs for a reasonable accommodation, and engaging in the interactive process. Employees do not have to provide a doctor's certification when returning from baby bonding or other qualified leaves specified under FMLA and/or CFRA. Except in very limited circumstances, an employee who exercises their right to take FMLA and/or CFRA leave has a right to reinstatement to the same or comparable position, pursuant to the conditions, restrictions and exceptions outlined under the FMLA and CFRA laws.

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III. PROCEDURE

Responsible Party	Action
Employee	1. Request an LOA designating FMLA and/or CFRA at least thirty (30) calendar days in advance, where practicable, by completing the Leave of Absence Request Form available on the InfoNet and submitting it to HR. 2. When applicable, provide a certification by the health care provider meeting the requirements under FMLA and/or CFRA, as applicable, that verifies the serious health condition of the employee, employee's Spouse, Registered Domestic Partner, Child(regardless of age or dependency status), Parent, grandparent, grandchild, sibling or Designated Person, including a covered service member, and outlines the anticipated duration of the leave. 3. Initiate contact with HR regarding continuation of benefits, use of PTO, where applicable, and any required payment arrangements. 4. Maintain regular communication with HR regarding the leave status and expected return to work. 5. If applicable, continue to timely pay employee share of health insurance premiums while on approved FMLA and/or CFRA to HR. 6. If Personal LOA continues after approved FMLA and/or CFRA period has been exhausted and still receiving a CalOptima Health payroll check, continue to timely pay the employee share of health insurance premiums to HR. 7. If Personal LOA continues after approved FMLA and/or CFRA period has been exhausted and no longer in active status, enroll in COBRA and make timely payments to CalOptima Health's third-party administrator. 8. Provide the required documentation to return to work, with or without a reasonable accommodation, on the agreed upon date.

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Responsible Party	Action
Human Resources (HR)	1. Ensure that all required notices pursuant to FMLA and CFRA are posted and disseminated as required by law (General Notice). 2. Upon receipt of a request by employee for FMLA and/or CFRA leave, or upon knowledge that an employee's leave may be for an FMLA/CFRA-qualifying reason, notify the employee of the employee's eligibility to take FMLA/CFRA leave **within five (5) business days,** absent extenuating circumstances (Rights and Responsibilities Notice). If the employee is not eligible for FMLA/CFRA leave, state at least one (1) reason why the employee is not eligible. 3. Designate leave as FMLA/CFRA qualifying and give notice of the designation to the employee **within five (5) business days**, absent extenuating circumstances (Designation Notice). 4. If applicable, ensure that required documentation (i.e., medical certification for serious health condition) has been submitted and has been completed thoroughly by the employee and/or health care provider. 5. Manage and process the LOA request, including any requested leave extensions or change to intermittent or reduced work schedule. 6. Help the employee with a plan to transition back to work, when applicable. 7. Engage in an interactive process with the employee, where applicable.
Supervisor and/or Manager	1. Notify HR upon knowledge that an employee may need to take a FMLA and/or CFRA-qualifying leave of absence, including intermittent leave or leave on a reduced schedule (for example, employee is hospitalized, employee requests time off to care for a sick Parent or Child or for baby-bonding purposes, etc.). 2. Notify HR if an employee provides a return-to-work status update.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.8018: Paid Time Off (PTO)
B. CalOptima Health Policy GA.8037: Leave of Absence
C. CalOptima Health Policy GA.8038: Personal Leave of Absence
D. CalOptima Health Policy GA.8039: Pregnancy Disability Leave and Related Workplace Accommodation
E. CalOptima Health Policy GA.8041: Workers' Compensation Program
F. Government Code § 12945.2 *et seq*. (CFRA)

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G. Leave of Absence Request Form
H. Title 2, California Code of Regulations § 11035 *et. seq*. (Pregnancy Regulations)
I. Title 2, California Code of Regulations § 11087 *et seq*. (CFRA Regulations)
J. Title 29, Code of Federal Regulations (C.F.R.) Part 825 *et seq*. (FMLA Regulations)
K. Title 29, United States Code section 2601 *et seq*. (FMLA)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act(CFRA) Leaves of Absence	Administrative
Revised	08/07/2014	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence	Administrative
Revised	06/07/2018	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence	Administrative
Revised	12/20/2021	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence	Administrative
Revised	05/04/2023	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence	Administrative
Revised	12/05/2024	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence	Administrative

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IX. GLOSSARY

Term	Definition
Child	The biological, adopted, foster, or stepchild, legal ward, or a child of a person standing in loco parentis who is under 18 years of age. A person is in loco parentis to a child if he or she assumes parental status and discharges parental duties. The California Family Rights Act (CFRA) also includes a child of any age and a child of an employee's Registered Domestic Partner.
Designated Person	A term used to describe an individual related to the employee by blood or whose association with the employee is equivalent to a family relationship.
Leave of Absence (LOA)	A term used to describe an authorized period of time off longer than five (5) days that an employee is to be away from their primary job, while maintaining the status of employee.
Paid Time Off (PTO) Exhaustion	Paid Time Off (PTO) will be applied in increments of no less than one quarter hour (fifteen (15) minutes) when less than a full day of PTO is available. When accrued PTO balance is less than one quarter hour (fifteen (15) minutes), PTO is considered to be exhausted with the exception of PTO pay on termination.
Parent	The biological, adoptive, step or foster parent of an employee or an individual who stands or stood in loco parentis to an employee when the employee was a child. The California Family Rights Act (CFRA) also includes parents-in-law.
Qualifying Exigency	The military leave entitlement helps families of military service members manage their affairs while a covered military service member is on active duty or called to covered active duty status (or has been notified of an impending call or order to covered active duty). According to the FMLA, 29 C.F.R. section 825.126, a Qualifying Exigency could include the following: 1. Short-notice deployment; 2. Military events and related activities; 3. Childcare and school activities; 4. Financial and legal arrangements; 5. Counseling; 6. Rest and recuperation; 7. Post-deployment activities; 8. Parental care; or 9. Additional activities not encompassed in the other categories but agreed to by the employer and employee.
Registered Domestic Partner	Registered domestic partners can be any couples, regardless of their sex. Only domestic partners who have registered with the State of California – or who formed a substantially equivalent legal union in another jurisdiction – qualify as Registered Domestic Partners.
Spouse	Defined as a husband or a wife. For purposes of this definition, husband or wife refers to the other person with whom an individual entered into marriage as defined or recognized under state law for purposes of marriage in the State in which the marriage was entered into (often referred to as "the place of celebration"). This definition includes individuals in same sex or common law marriages.

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Policy:	GA.8041
Title:	**Workers' Compensation Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	12/05/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines CalOptima Health's protocols and procedures for Employees who sustain a work-related injury or illness.

II. POLICY

A. Workers' Compensation provides benefits to Employees who sustain an injury or illness arising out of and during the course and scope of their employment. Employees may not be eligible for Workers' Compensation benefits for injuries that arise from voluntary participation in any off-duty, recreational, social, or athletic activity that is not part of work-related duties.

B. Workers' Compensation is a state mandated benefit and includes the following:

1. California mandated benefits:

   a. Medical care: Medical treatment to help recover from an injury or illness caused by work.

   b. Temporary disability benefits: Payments if wages are lost due to an injury or illness preventing an Employee from working while recovering.

   c. Permanent disability benefits: Payments if an Employee does not completely recover from a work-related injury or illness.

   d. Supplemental job displacement benefits: Vouchers to help pay for retraining or skill enhancement if an Employee does not completely recover from a work-related injury or illness and cannot return to work for CalOptima Health.

   e. Death benefits: Payments to an Employee's spouse, children, or other dependents in the event of death due to a work-related injury or illness.

2. This policy applies to Employees who reside and work in California, out-of-state Employees should contact Human Resources for the Workers' Compensation benefits and procedures applicable to their state.

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C. Employees are required to report all work-related injuries and illnesses to their supervisor and Human Resources immediately, regardless of how minor the injury or illness may be.

D. In accordance with CalOptima Health Policy GA.8016: Unusual Occurrence, serious injuries, illnesses, or deaths resulting from an Unusual Occurrence (i.e., fire, earthquake, bomb threat, violent intruder, active shooter, civil unrest) on CalOptima Health property, shall also be reported to the Manager of Environmental Health and Safety.

E. Workers' Compensation Leave of Absence

1. An Employee who is eligible for Workers' Compensation benefits shall be placed on Workers' Compensation Leave of Absence if the injury or illness prevents the Employee from performing their job duties.

2. For eligible Employees, the Workers' Compensation Leave of Absence shall run concurrently with the Family and Medical Leave Act (FMLA) Leave and California Family Rights Act (CFRA) Leave (See CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence for details).

a. ~~Workers' Compensation Leave of Absence~~Exhaustion of FMLA/CFRA Leave: An employee may be eligible to take a Personal Leave of Absence (LOA) following exhaustion of their FMLA or CFRA LOA in accordance with CalOptima Health Policy GA.8038: Personal Leave of Absence. The Workers' Compensation LOA shall run concurrently with the Personal LOA. CalOptima Health may engage in the interactive process with an employee who has exhausted their leave under FMLA and/or CFRA, if applicable, and requires additional time off due to the employee's qualifying disability.

3. Workers' Compensation LOA shall continue until one of the following occurs:

~~a.~~b. The Employee is released to return to regular work by an authorized physician.

~~b.~~c. The Employee is released to return to work with restrictions CalOptima Health can accommodate.

~~c.~~d. The Employee is declared permanent and stationary by an authorized physician, and it is determined that the Employee is unable to perform the essential functions of their job, with or without reasonable accommodation.

~~d.~~e. Employment with CalOptima Health is terminated.

F. Temporary Disability

1. Employees with a compensable Workers' Compensation injury or illness may be eligible for temporary disability benefits if:

a. An authorized physician provides documentation advising the Employee is unable to perform their job duties for more than three (3) calendar days, or the Employee is hospitalized overnight.

b. CalOptima Health is unable to accommodate the temporary work restrictions provided by the authorized physician.

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2. Temporary disability payments are paid to the injured or ill Employee while they are recovering from the injury or illness and unable to work. The amount of the temporary disability benefit will generally be two-thirds (2/3) of the Employee's average weekly earnings; subject to maximums and minimums set by the State Legislature.

3. While receiving temporary disability payments, an Employee may ~~elect~~make a one (1) time request to ~~use~~coordinate those payments with accrued paid time off (PTO) to ~~supplement their income up to~~receive one hundred percent (100%) of their ~~regular earnings.~~ total pay until PTO Exhaustion is reached. Supplemental PTO must be used on consecutive calendar days within each pay period, in accordance with the employee's assigned work schedule, until exhausted.

4. Temporary disability payments are not paid for the first three (3) calendar days (waiting period) of lost time. The waiting period is waived if the disability continues for more than fourteen (14) calendar days, or the Employee is hospitalized as an inpatient. An Employee may use accrued PTO during this waiting period.

G. Accrued PTO may also be utilized while the claim is in delayed status to determine compensability. If the claim is subsequently accepted, PTO accruals will be restored, and payroll wages will be adjusted accordingly.

III. PROCEDURE

A. To file a Workers' Compensation claim, the Employee must complete and submit the following forms to Human Resources:

1. Workers' Compensation – Employee Incident Report

2. Claim Form (DWC-1)

B. Employees who have a work-related injury or illness should seek medical care at an authorized industrial clinic.

1. Medical care will be provided through a Medical Provider Network (MPN), which is a group of health care providers (physicians and specialty providers) who specialize in industrial injuries and illnesses. The MPN providers will manage and direct any medical care necessary to relieve or cure the effects of the work-related injury or illness. For further information on CalOptima Health's MPN, refer to MPN Employee Notification provided at the time of hire and by the insurance carrier at the time a claim is filed.

   a. For a list of designated industrial clinics for initial treatment please see Treatment Facilities for Industrial Injuries.

C. If a valid Pre-designation of Personal Physician Form is filed with Human Resources prior to an injury or onset of illness, the Employee may seek medical treatment with their personal physician.

D. For life threatening injuries or emergencies, call 911 immediately or obtain medical treatment at the nearest emergency medical center. Following the emergency treatment, the Employee will be referred to a physician within the MPN.

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E. Employees are responsible for providing work status reports from the Workers' Compensation physician to Human Resources following each medical visit.

F. While on a Workers' Compensation Leave of Absence, Employees shall remain in contact with CalOptima Health's Human Resources Department and their supervisor(s) regarding their current return to work status.

G. If an Employee is provided with work limitations, Human Resources will partner with the Employee's supervisor, other CalOptima Health departments, and/or our workers' compensation third-party administrator to identify a Transitional, Modified, or Alternative Work Assignment within the restrictions.

a. If a Transitional, Modified, or Alternative Work Assignment within the restrictions is not available at CalOptima Health, an offsite placement at a non-profit organization may be considered.

H. Medical appointments should be scheduled in a manner that provides the least disruption to the Employee's normal work schedule.

I. Temporary disability benefits are not payable for absences or lost time from work to attend medical or physical therapy appointments. The Employee will utilize accrued PTO, make up time away from work (with supervisor approval), or take unpaid time off -if PTO accruals are not sufficient.

J. An employee on a Continuous LOA is not eligible to receive certain supplemental compensation in accordance with CalOptima Health Policy GA.8037 Leave of Absence.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Policy GA.8016: Unusual Occurrence
B. CalOptima Policy GA.8037: Leave of Absence
C. CalOptima Policy GA.8040: Family and Medical Leave Act and California Family Rights Act Leave
D. Medical Provider Network (MPN) Employee Notification
E. Pre-designation of Personal Physician form
F. Treatment Facilities for Industrial Injuries
G. Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility
H. Workers' Compensation Employee Incident Report

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors

12/20/2021	Special Meeting of the CalOptima Board of Directors
11/02/2023	Regular Meeting of the CalOptima Health Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8041	Worker's Compensation Leave of Absence	Administrative
Revised	08/07/2014	GA.8041	Worker's Compensation Leave of Absence	Administrative
Revised	06/07/2018	GA.8041	Worker's Compensation Leave of Absence	Administrative
Revised	12/20/2021	GA.8041	Worker's Compensation Leave of Absence	Administrative
Revised	11/02/2023	GA.8041	Worker's Compensation Program	Administrative
Revised	12/05/2024	GA.8041	Worker's Compensation Program	Administrative

IX. GLOSSARY

Term	Definition
Continuous Leave of Absence (LOA)	Leave that is taken continuously and not broken into separate blocks of time.
Employee	For the purposes of this policy Employees include regular full-time, regular part-time, and as-needed Employees of CalOptima Health.
Paid Time Off (PTO) Exhaustion	Paid Time Off (PTO) will be applied in increments of no less than one quarter hour (fifteen (15) minutes) when less than a full day of PTO is available. When accrued PTO balance is less than one quarter hour (fifteen (15) minute), PTO is considered to be exhausted with the exception of PTO pay on termination.
Transitional, Modified, or Alternative Work Assignment	Temporary work modification given to an injured Employee to accommodate their physical limitations while recovering from the injury.
Unusual Occurrence	Any event which jeopardizes or has the potential to jeopardize the health and/or safety of CalOptima Health Employees, Members, and/or the community, including, but not limited to, physical injury and death, and/or property damage
Workers' Compensation	State mandated benefits provided to Employees who sustain a work-related injury or illness.
Workers' Compensation Leave of Absence	A term used to describe a leave of absence for Employees who sustain an injury or illness arising out of and during the course and scope of their employment. The absence must be longer than three (3) calendar days of lost time, or less if the Employee is hospitalized as an inpatient.

Policy:	GA.8041
Title:	**Workers' Compensation Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	12/05/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

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B. Workers' Compensation is a state mandated benefit and includes the following:

1. California mandated benefits:

   a. Medical care: Medical treatment to help recover from an injury or illness caused by work.

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   e. Death benefits: Payments to an Employee's spouse, children, or other dependents in the event of death due to a work-related injury or illness.

2. This policy applies to Employees who reside and work in California, out-of-state Employees should contact Human Resources for the Workers' Compensation benefits and procedures applicable to their state.

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C. Employees are required to report all work-related injuries and illnesses to their supervisor and Human Resources immediately, regardless of how minor the injury or illness may be.

D. In accordance with CalOptima Health Policy GA.8016: Unusual Occurrence, serious injuries, illnesses, or deaths resulting from an Unusual Occurrence (i.e., fire, earthquake, bomb threat, violent intruder, active shooter, civil unrest) on CalOptima Health property, shall also be reported to the Manager of Environmental Health and Safety.

E. Workers' Compensation Leave of Absence

1. An Employee who is eligible for Workers' Compensation benefits shall be placed on Workers' Compensation Leave of Absence if the injury or illness prevents the Employee from performing their job duties.

2. For eligible Employees, the Workers' Compensation Leave of Absence shall run concurrently with the Family and Medical Leave Act (FMLA) Leave and California Family Rights Act (CFRA) Leave (See CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence for details).

   a. Exhaustion of FMLA/CFRA Leave: An employee may be eligible to take a Personal Leave of Absence (LOA) following exhaustion of their FMLA or CFRA LOA in accordance with CalOptima Health Policy GA.8038: Personal Leave of Absence. The Workers' Compensation LOA shall run concurrently with the Personal LOA. CalOptima Health may engage in the interactive process with an employee who has exhausted their leave under FMLA and/or CFRA, if applicable, and requires additional time off due to the employee's qualifying disability.

3. Workers' Compensation LOA shall continue until one of the following occurs:

   b. The Employee is released to return to regular work by an authorized physician.

   c. The Employee is released to return to work with restrictions CalOptima Health can accommodate.

   d. The Employee is declared permanent and stationary by an authorized physician, and it is determined that the Employee is unable to perform the essential functions of their job, with or without reasonable accommodation.

   e. Employment with CalOptima Health is terminated.

F. Temporary Disability

1. Employees with a compensable Workers' Compensation injury or illness may be eligible for temporary disability benefits if:

   a. An authorized physician provides documentation advising the Employee is unable to perform their job duties for more than three (3) calendar days, or the Employee is hospitalized overnight.

   b. CalOptima Health is unable to accommodate the temporary work restrictions provided by the authorized physician.

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2. Temporary disability payments are paid to the injured or ill Employee while they are recovering from the injury or illness and unable to work. The amount of the temporary disability benefit will generally be two-thirds (2/3) of the Employee's average weekly earnings; subject to maximums and minimums set by the State Legislature.

3. While receiving temporary disability payments, an Employee may make a one (1) time request to coordinate those payments with accrued paid time off (PTO) to receive one hundred percent (100%) of their total pay until PTO Exhaustion is reached. Supplemental PTO must be used on consecutive calendar days within each pay period, in accordance with the employee's assigned work schedule, until exhausted.

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2. Claim Form (DWC-1)

B. Employees who have a work-related injury or illness should seek medical care at an authorized industrial clinic.

1. Medical care will be provided through a Medical Provider Network (MPN), which is a group of health care providers (physicians and specialty providers) who specialize in industrial injuries and illnesses. The MPN providers will manage and direct any medical care necessary to relieve or cure the effects of the work-related injury or illness. For further information on CalOptima Health's MPN, refer to MPN Employee Notification provided at the time of hire and by the insurance carrier at the time a claim is filed.

a. For a list of designated industrial clinics for initial treatment please see Treatment Facilities for Industrial Injuries.

C. If a valid Pre-designation of Personal Physician Form is filed with Human Resources prior to an injury or onset of illness, the Employee may seek medical treatment with their personal physician.

D. For life threatening injuries or emergencies, call 911 immediately or obtain medical treatment at the nearest emergency medical center. Following the emergency treatment, the Employee will be referred to a physician within the MPN.

E. Employees are responsible for providing work status reports from the Workers' Compensation physician to Human Resources following each medical visit.

F. While on a Workers' Compensation Leave of Absence, Employees shall remain in contact

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with CalOptima Health's Human Resources Department and their supervisor(s) regarding their current return to work status.

G. If an Employee is provided with work limitations, Human Resources will partner with the Employee's supervisor, other CalOptima Health departments, and/or our workers' compensation third-party administrator to identify a Transitional, Modified, or Alternative Work Assignment within the restrictions.

   a. If a Transitional, Modified, or Alternative Work Assignment within the restrictions is not available at CalOptima Health, an offsite placement at a non-profit organization may be considered.

H. Medical appointments should be scheduled in a manner that provides the least disruption to the Employee's normal work schedule.

I. Temporary disability benefits are not payable for absences or lost time from work to attend medical or physical therapy appointments. The Employee will utilize accrued PTO, make up time away from work (with supervisor approval), or take unpaid time off if PTO accruals are not sufficient.

J. An employee on a Continuous LOA is not eligible to receive certain supplemental compensation in accordance with CalOptima Health Policy GA.8037 Leave of Absence.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Policy GA.8016: Unusual Occurrence
B. CalOptima Policy GA.8037: Leave of Absence
C. CalOptima Policy GA.8040: Family and Medical Leave Act and California Family Rights Act Leave
D. Medical Provider Network (MPN) Employee Notification
E. Pre-designation of Personal Physician form
F. Treatment Facilities for Industrial Injuries
G. Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility
H. Workers' Compensation Employee Incident Report

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/02/2023	Regular Meeting of the CalOptima Health Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8041	Worker's Compensation Leave of Absence	Administrative
Revised	08/07/2014	GA.8041	Worker's Compensation Leave of Absence	Administrative
Revised	06/07/2018	GA.8041	Worker's Compensation Leave of Absence	Administrative
Revised	12/20/2021	GA.8041	Worker's Compensation Leave of Absence	Administrative
Revised	11/02/2023	GA.8041	Worker's Compensation Program	Administrative
Revised	12/05/2024	GA.8041	Worker's Compensation Program	Administrative

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IX. GLOSSARY

Term	Definition
Continuous Leave of Absence (LOA)	Leave that is taken continuously and not broken into separate blocks of time.
Employee	For the purposes of this policy Employees include regular full-time, regular part-time, and as-needed Employees of CalOptima Health.
Paid Time Off (PTO) Exhaustion	Paid Time Off (PTO) will be applied in increments of no less than one quarter hour (fifteen (15) minutes) when less than a full day of PTO is available. When accrued PTO balance is less than one quarter hour (fifteen (15) minute), PTO is considered to be exhausted with the exception of PTO pay on termination.
Transitional, Modified, or Alternative Work Assignment	Temporary work modification given to an injured Employee to accommodate their physical limitations while recovering from the injury.
Unusual Occurrence	Any event which jeopardizes or has the potential to jeopardize the health and/or safety of CalOptima Health Employees, Members, and/or the community, including, but not limited to, physical injury and death, and/or property damage
Workers' Compensation	State mandated benefits provided to Employees who sustain a work-related injury or illness.
Workers' Compensation Leave of Absence	A term used to describe a leave of absence for Employees who sustain an injury or illness arising out of and during the course and scope of their employment. The absence must be longer than three (3) calendar days of lost time, or less if the Employee is hospitalized as an inpatient.

Policy:	GA.8060
Title:	**Recruitment, Selection, and Hiring**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	05/04/2023
Revised Date:	12/05/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes merit-based hiring practices as the foundation of CalOptima Health's personnel administration, including recruitment, selection, and hiring.

II. POLICY

A. CalOptima Health focuses on attaining a well-qualified, skilled, and representative workforce through open recruitment and fair, job-related assessments of applicants. Hiring and Promotion decisions are competitive, based on merit and are not made with regard to political affiliation, race, color, religion, creed, ancestry, national origin, sex (pregnancy or gender), sexual orientation, gender identity and expression, medical condition, genetic information, marital status, age (40 and over), mental and physical disability, military or veteran status, or other protected characteristics or activities.

B. The Chief Human Resources Officer (CHRO) is directed to administer CalOptima Health's recruitment, selection and hiring program consistent with this policy. Human Resources (HR) will establish and maintain recruitment, selection and hiring guidelines in support of this policy. The CHRO, with approval of the Chief Executive Officer (CEO), may authorize amendments to the recruitment, selection and hiring guidelines to ensure best practices and compliance with local, state, and federal employment regulations.

C. Except as indicated herein, this policy shall apply to recruitment, selection and hiring for all regular staff and leadership, full-time ~~and,~~ part-time, and Limited Term, ~~As Needed, Paid Interns, and Extra Help~~ positions. Excepted positions are as follows:

1. CEO: The CalOptima Health Board of Directors (Board) shall determine the method for recruiting and evaluating the qualifications of applicants when filling the CEO position.

2. Paid Interns, Unpaid Interns, As-Needed, temporary or seasonal positions, residents, and fellows;

~~2.~~3. Job re-evaluations resulting in a job re-classification approved by Human Resources (HR);

~~3.~~4. Appointment through a reasonable accommodation approved by HR; and

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~~4.~~5. Those to be filled by a temporary appointment.

a. In rare cases, the CHRO may authorize a Hiring Manager to waive some or all the requirements of this policy to make a temporary appointment of a qualified employee or non-employee when the CEO determines it is in the best interest of the agency to immediately fill a vacancy or to provide for a transition and/or training period in the advance of a position becoming vacant. A temporary appointment shall not extend beyond the time needed to conduct recruitment and selection in accordance with this policy. Temporary appointments shall not be continued for more than six (6) months from date of appointment unless an extension of no more than one (1) year from the original date of the temporary appointment is recommended by the CHRO and approved by the CEO. An employee appointed in to a temporary assignment may be released from service or returned to their prior job classification at any time.

III. PROCEDURE

A. The CHRO shall determine the merit-based methods for recruiting, evaluating the qualifications of applicants, and filling positions. A Hiring Manager may suggest appropriate methods of recruitment and selection to HR for consideration.

B. Job Announcements

1. HR shall prepare and post job announcements on CalOptima Health's Internet and Intranet as well as various external employment websites to attract a diverse pool of qualified applicants. The posting period shall be at least fourteen (14) consecutive calendar days before the selection process will begin. Job announcements shall include, at a minimum, the general duties of the position, gender neutral language, minimum qualifications, preferred qualifications (when applicable~~, an~~), Equal Employment Opportunity statement~~, the~~, Diversity, Equity and Inclusion (DEI) statement, disability accommodation statement, application deadline (when applicable~~,~~), and the salary range of the position as required by State law.

C. Qualification of Applicants

1. HR will review each application received by the application deadline, if any, to determine whether the applicant meets the minimum qualifications stated in the job announcement. Applicants may be required to submit evidence of required education, training, licensure, experience, or required special qualifications as requested by HR.

2. Rehire Eligibility: HR will engage in a comprehensive CalOptima Health employment history review of applicants who apply for rehire. Considerations for rehire eligibility include historical performance evaluations and corrective actions, and reason for separation.

~~1.~~3. Whenever HR rejects an application for ~~lack of minimum qualifications~~failure to meet eligibility, written notice of such rejection shall be emailed to the applicant.

D. Disqualification of Applicants

1. Any of the following actions or deficiencies may constitute sufficient grounds for the disqualification of an applicant:

a. Failure to submit an application or application materials correctly or by the final application deadline, if any;

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b. False or misleading statement(s) of a material fact on the application or application materials;

c. Failure to appear for, or pass, any portion of the selection process; and/or

d. Actual or attempted use of any method to obtain an advantage to which the applicant is not rightfully entitled.

E. Content of Selection Procedures

1. All parts of any recruitment, selection, and background check shall be conducted only as authorized by HR. Hiring Managers and interview panelists shall not conduct background checks, including reference checks. HR shall have the authority to revoke, cancel, or nullify the results of any or all portions of any selection procedure, which do not have such authorization. HR shall have the authority to disqualify the Chair and/or panel members and appoint new panel members if there are signs of potential bias.

2. HR shall determine the content and combinations of selection tools to be used, the weights assigned to each, and the passing point or qualifying score. Selection processes will be applied consistently to all qualified applicants and may include, but are not limited to:

a. Appraisals of education, training, experience, knowledge, and ability, including a determination the applicant meets the minimum qualifications;

b. Oral interviews;

c. Performance and/or written exams;

d. Assessment exercises;

e. Medical examinations; and/or

f. Background checks.

F. Oral Interview Panel(s)

1. HR ~~may~~shall authorize an oral interview panel to evaluate, assess, and rate applicants' job-related qualifications.

2. The same interview method will be applied for all applicants interviewed, which may include but is not limited to consistency of panel raters where possible, interview questions, and time allotted for the interview.

3. Only persons authorized by HR shall serve on oral interview panels as raters.

a. Oral interview panels will consist of a minimum of two (2) raters.

b. At least one-third (1/3) of the panel raters shall be technically qualified in the pertinent occupational field.

c. Applicants in a selection procedure shall not serve as raters.

d. Completed interview guides shall be submitted directly to HR no later than twenty-four (24) hours after the completion of the interview.

4. A minimum of three (3) qualified applicants will be interviewed. When less than three (3) applicants are qualified only those applicants who are qualified will be interviewed.

5. HR shall determine the relative weight the overall interview score shall have in relation to other tests that may constitute part of the selection procedure. HR ~~will~~may consult with the Hiring Manager in determining weights.

6. Raters shall be provided instruction on evaluation standards and procedures by HR prior to serving on an interview panel as a member or a Chair and shall rate applicants according to such standards and procedures. During the interview, each applicant shall be allowed an opportunity to present additional information on their qualifications as they relate to the position. This shall be separate and distinct from specific questions the panel asks the applicant.

7. Hiring Managers may select an applicant for hire from any of the three (3) highest scoring applicants who successfully passed the selection process. ~~The selected applicant~~If multiple positions are hired from the same recruitment, the applicant selected initially will be removed from the scoring to determine the next three (3) highest scoring applicants. The selected applicant(s) will be required to successfully complete the background check in accordance with CalOptima Health Policy GA.8030: Background Check.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.8030: Background Check
B. CalOptima Health Recruitment, Selection, and Hiring Guidelines

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/04/2023	GA.8060	Recruitment, Selection, and Hiring	Administrative
Revised	12/05/2024	GA.8060	Recruitment, Selection, and Hiring	Administrative

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IX. GLOSSARY

Term	Definition
As-Needed	Employees called to work sporadically on an as-needed basis. These employees may not have regularly scheduled hours and do not earn any benefits. As-Needed employees are employed for an indefinite duration and must work less than one thousand (1,000) hours per fiscal year.
Demotion	A change of employee's position to one at a lower Salary Schedule pay grade, whether in the same or a different department. A demotion may be either voluntary or involuntary.
Extra Help	Type of retired annuitant employment as authorized by Government Code.
Hiring Manager	The supervisor or manager responsible for making final hiring decision.
Limited Term	Full time position hired for a specified time period.
Paid Interns~~Intern~~	A Paid ~~interns are~~Intern is considered an As-Needed ~~employees~~employee and ~~should~~must be ~~concurrently~~ enrolled in an accredited college or university two- or four-year degree program, an accredited vocational institution, or a graduate ~~courses.~~program. They may receive school credit for the internship.
Promotion	Occurs when an employee is selected for a job with a higher pay grade.
Transfer	Occurs when an employee moves to a different job title having the same pay grade.
Unpaid Intern	An Unpaid Intern meets the DOL criteria and is exempt from the minimum wage requirements. They must be enrolled in an accredited college or university two- or four-year degree program, an accredited vocational institution, or a graduate program, and must receive school credit for the internship.

Policy:	GA.8060
Title:	**Recruitment, Selection, and Hiring**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
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Revised Date:	12/05/2024
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4. Appointment through a reasonable accommodation approved by HR; and

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IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.8030: Background Check
B. CalOptima Health Recruitment, Selection, and Hiring Guidelines

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/04/2023	GA.8060	Recruitment, Selection, and Hiring	Administrative
Revised	12/05/2024	GA.8060	Recruitment, Selection, and Hiring	Administrative

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Extra Help	Type of retired annuitant employment as authorized by Government Code.
Hiring Manager	The supervisor or manager responsible for making final hiring decision.
Limited Term	Full time position hired for a specified time period.
Paid Intern	A Paid Intern is considered an As-Needed employee and must be enrolled in an accredited college or university two- or four-year degree program, an accredited vocational institution, or a graduate program. They may receive school credit for the internship.
Promotion	Occurs when an employee is selected for a job with a higher pay grade.
Transfer	Occurs when an employee moves to a different job title having the same pay grade.
Unpaid Intern	An Unpaid Intern meets the DOL criteria and is exempt from the minimum wage requirements. They must be enrolled in an accredited college or university two- or four-year degree program, an accredited vocational institution, or a graduate program, and must receive school credit for the internship.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
9. Adopt Resolution No. 24-1205-03 Amending CalOptima Health's Conflict of Interest Code

Contacts
Michael Hunn, Chief Executive Officer, (714) 246-8570
Steve Eckberg, Chief Human Resources Officer, (657) 328-9053

Recommended Actions
1. Adopt Resolution No. 24-1205-03 adopting an amended Conflict of Interest Code, which supersedes all prior Conflict of Interest Codes and amendments previously adopted by CalOptima Health and the Orange County Board of Supervisors; and
2. Upon adoption of the resolution, direct the Clerk of the Board of Directors to submit the Conflict of Interest Code to the Orange County Board of Supervisors for review and approval.

Background
The Political Reform Act requires that state and local government agencies adopt and periodically update their conflict of interest codes. The Fair Political Practices Commission (FPPC) adopted a standard model conflict of interest code (Model Code) that, together with amendments thereto, may be adopted by local public agencies and incorporated by reference.[1] CalOptima Health's Conflict of Interest Code consists of the Model Code adopted by reference on January 6, 2011, along with Exhibit A: Designated Filer Positions and Disclosures Categories and Exhibit B: Disclosure Description. An amended Exhibit A to CalOptima Health's Conflict of Interest Code was adopted by the CalOptima Health Board of Directors on December 1, 2022. Exhibit A lists designated positions, which make or participate in making decisions that may have a material effect on economic interests, and Exhibit B specifies the disclosure categories, which list the kinds of economic interests that are reportable by the designated positions.

Discussion
When designated positions or reporting categories are added or changed, local agencies are required by Government Code section 87306 to make changes to their conflict of interest code to reflect these changed circumstances. On May 2, 2024, the CalOptima Health Board of Directors adopted a new Salary Schedule with an updated list of CalOptima Health employee positions and job titles. The updates included addition, deletion, and renaming positions.

The changes to the Salary Schedule therefore require that CalOptima Health's Conflict of Interest Code be updated to accurately reflect the list of positions that make or participate in making governmental decisions that may foreseeably have a material financial effect on a financial interest. All individuals in designated positions will still be required to complete CalOptima Health's Supplement to FPPC Form 700. The proposed changes to Exhibit A of the CalOptima Health Conflict of Interest Code update positions that have been added, deleted, or renamed.

[1] 2 CCR § 18730.

~~In addition, changes are required to the disclosure categories listed in Exhibit B. The FPPC General Counsel has opined that "conflict of interest code disclosure categories must be narrowly tailored to the type of economic interests that will foreseeably be affected by a designated employee's decision making."[2] The FPPC regulation also notes that designated positions are not required to report gifts outside an agency's jurisdiction if the purpose of disclosure of the source of the gift does not have some connection with or bearing upon the functions or duties of the position for which the reporting is required.[3] Accordingly, changes are proposed to Exhibit B of the CalOptima Health's Conflict of Interest Code to ensure that disclosure requirements for each position are narrowly tailored to the type of economic interests that will foreseeably be materially affected by a designated employee's decision making.~~

Rev. 12/5/24

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Adoption of Resolution No. 24-1205-03 is necessary to reflect updates required by law (i) to reflect updates to certain positions that have been added, deleted, or renamed; and (ii) to update disclosure categories to conform with the County of Orange Standard Disclosure Categories and to tailor the disclosure requirements to the type of economic interests that will foreseeably be affected by each position.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Resolution No. 24-1205-03 Adopting a Conflict of Interest Code Which Supersedes All Prior Conflict of Interest Codes and Amendments Previously Adopted.
2. Draft Conflict of Interest Code – Exhibits A and B

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

[2] See e.g., May 7, 2012, Memorandum from Zackery P. Morazzini, General Counsel of FPPC.
[3] 2 CCR § 18730.1.

RESOLUTION NO. 24-1205-03

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

ADOPTING AN AMENDED CONFLICT OF INTERST CODE WHICH SUPERSEDES ALL PRIOR CONFLICT OF INTEREST CODES AND AMENDMENTS PREVIOUSLY ADOPTED

WHEREAS, the Political Reform Act of 1974, Government Code Section 81000 *et seq.* ("**the Act**"), requires a local government agency to adopt a Conflict of Interest Code pursuant to the Act and conduct a biennial review of designated positions and disclosure categories;

WHEREAS, in conformity with the Act, the Orange County Health Authority, dba CalOptima Health, ("**CalOptima Health**") previously adopted a Conflict of Interest Code that incorporated by reference the standard model conflict of interest code adopted by the Fair Political Practices Commissions pursuant to Title 2, California Code of Regulations, Section 18730; and

WHEREAS, amendments to the Act and CalOptima Health operational changes have in the past and foreseeably will in the future require conforming amendments to be made to CalOptima Health's Conflict of Interest Code; and

WHEREAS, CalOptima Health's Conflict of Interest Code must be amended to reflect updates to designated positions and disclosures categories.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. The terms of Title 2, California Code of Regulations, Section 18730, and any amendments to it duly adopted by the Fair Political Practices Commission, and all additional guidance by the Fair Political Practices Commission, are hereby incorporated by reference, and together, with the attached amended Exhibits A and B in which members and employees are designated and disclosure categories are set forth, constitute the Conflict of Interest Code of CalOptima Health.

Section 2. The provisions of all Conflict of Interest Codes and amendments thereto previously adopted by CalOptima Health are hereby superseded.

Section 3. The CalOptima Health Clerk of the Board is hereby authorized and directed to forward a copy of this Resolution and CalOptima Health's amended Conflict of Interest Code to the Clerk of the Orange County Board of Supervisors for review and approval by the Orange County Board of Supervisors as required by California Government Code Section 87303.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima Health this 5th day of December 2024.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Isabel Becerra, Chair, CalOptima Health Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

Conflict of Interest Code EXHIBIT A
(Working Draft)
CalOptima Health policy GA.8012 Conflicts of Interest

Entity: Other Misc Authorities, Districts and Commissions

Agency: CalOptima

Position	Disclosure Category	Files With	Status
Associate Director I	OC-41	COB	Unchanged
Associate Director II	OC-41	COB	Unchanged
Associate Director III	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Associate Director IV	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Buyer	OC-01	COB	Unchanged
Buyer, Int.	OC-01	COB	Unchanged
Buyer, Sr.	OC-01	COB	Unchanged
Chief Administrative Officer	OC-01	COB	Added
Reason: New job title			
Chief Compliance Officer	OC-01	COB	Unchanged
Chief Health Equity Officer	OC-01	COB	Unchanged
Chief Human Resources Officer	OC-01	COB	Renamed
Reason: Revised job title			
Chief Information Officer	OC-01	COB	Unchanged
Chief Medical Officer	OC-01	COB	Unchanged
Chief of Staff	OC-01	COB	Unchanged
Chief Operating Officer	OC-01	COB	Unchanged
Clerk of the Board	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Clinical Pharmacist	OC-20	COB	Unchanged
Consultant	OC-01	Agency	Unchanged
Consultant	OC-01	COB	Unchanged
Contract Administrator	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Contracts Manager	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Contracts Manager Sr.	OC-06	COB	Unchanged
Contracts Specialist	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Contracts Specialist Int.	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Contracts Specialist Sr.	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Controller	OC-01	COB	Unchanged
Deputy Chief Medical Officer	OC-01	COB	Unchanged
Deputy Clerk of the Board	OC-06	COB	Deleted
Reason: Job Title Eliminated			
Director I	OC-01	COB	Unchanged
Director II	OC-01	COB	Unchanged
Director III	OC-01	COB	Unchanged
Director IV	OC-01	COB	Unchanged
Director, Vendor Management	OC-01	COB	Deleted
Reason: Revised Job Title			
Enterprise Analytics Manager	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Executive Director	OC-01	COB	Unchanged
Financial Analyst I	OC-01	COB	Unchanged
Financial Analyst II	OC-01	COB	Unchanged
Financial Analyst III	OC-01	COB	Unchanged
Financial Analyst IV	OC-01	COB	Unchanged
Financial Reporting Analyst	OC-01	COB	Unchanged
Litigation Support Specialist	OC-41	COB	Unchanged
Manager, Accounting	OC-01	COB	Unchanged
Manager, Actuary	OC-01	COB	Unchanged
Manager, Audit and Oversight	OC-01	COB	Unchanged
Manager, Behavioral Health	OC-41	COB	Unchanged
Manager, Business Integration	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Manager, Case Management	OC-41	COB	Unchanged
Manager, Claims	OC-41	COB	Unchanged
Manager, Clinic Operations	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Manager, Clinical Pharmacists	OC-20	COB	Unchanged
Manager, Coding Quality	OC-06	COB	Category Changed

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Reason: Disclosure Category Incorrect			
Manager, Communications	OC-13	COB	Unchanged
Manager, Community Relations	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Manager, Contracting	OC-41	COB	Unchanged
Manager, Creative Branding	OC-13	COB	Deleted
Reason: Job Title Eliminated			
Manager, Cultural & Linguistics	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Manager, Customer Service	OC-41	COB	Unchanged
Manager, Electronic Business	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Manager, Encounters	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Manager, Environmental Health & Safety	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Manager, Finance	OC-01	COB	Unchanged
Manager, Financial Analysis	OC-01	COB	Unchanged
Manager, Government Affairs	OC-41	COB	Unchanged
Manager, Grievance & Appeals	OC-41	COB	Renamed
Reason: Revised job title			
Manager, Human Resources	OC-11	COB	Unchanged
Manager, Information Technology Services	OC-08	COB	Renamed
Reason: Revised Job Title			
Manager, Long Term Support Services	OC-41	COB	Unchanged
Manager, Marketing & Outreach	OC-06	COB	Deleted
Reason: Job Title Eliminated			
Manager, Marketing and Enrollment (PACE)	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Manager, Member Liaison Program	OC-41	COB	Unchanged
Manager, Member Outreach & Education	OC-41	COB	Unchanged
Manager, MSSP	OC-41	COB	Unchanged
Manager, OneCare (Clinical, Customer Service, or Sales)	OC-41	COB	Deleted
Reason: Job Title Eliminated			

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Manager, OneCare Clinical	OC-41	COB	Unchanged
Manager, OneCare Customer Service	OC-41	COB	Unchanged
Manager, Outreach & Enrollment	OC-41	COB	Unchanged
Manager, PACE Center	OC-41	COB	Unchanged
Manager, Population Health Management	OC-41	COB	Unchanged
Manager, Process Excellence	OC-41	COB	Unchanged
Manager, Program Implementation	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Manager, Provider Data Management Services	OC-41	COB	Unchanged
Manager, Provider Network	OC-41	COB	Unchanged
Manager, Provider Relations	OC-41	COB	Unchanged
Manager, Purchasing	OC-01	COB	Unchanged
Manager, QI Initiatives	OC-41	COB	Unchanged
Manager, Quality Analytics	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Manager, Quality Improvement	OC-41	COB	Unchanged
Manager, Regulatory Affairs and Compliance	OC-41	COB	Unchanged
Manager, Reporting & Financial Compliance	OC-01	COB	Unchanged
Manager, Strategic Development	OC-41	COB	Unchanged
Manager, Utilization Management	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Medical Case Manager	OC-41	COB	Unchanged
Medical Case Manager - LVN	OC-41	COB	Unchanged
Medical Director	OC-01	COB	Unchanged
Medical Services Case Manager	OC-41	COB	Category Changed
Reason: Disclosure Category Incorrect			
Nurse Practitioner (PACE)	OC-41	COB	Category Changed
Reason: Disclosure Category Incorrect			
OneCare Operations Manager	OC-41	COB	Unchanged
Pharmacy Resident	OC-20	COB	Unchanged
Pharmacy Services Specialist	OC-20	COB	Unchanged
Pharmacy Services Specialist, Int.	OC-20	COB	Unchanged

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Pharmacy Services Specialist, Sr.	OC-20	COB	Unchanged
Policy Advisor, Sr.	OC-41	COB	Unchanged
Principal Financial Analyst	OC-01	COB	Unchanged
Privacy Manager	OC-41	COB	Unchanged
Privacy Officer	OC-41	COB	Unchanged
Process Excellence Manager	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Process Excellence Manager II	OC-41	COB	Added
Reason: New Job Title			
Process Excellence Manager III	OC-41	COB	Added
Reason: New Job Title			
Process Excellence Manager IV	OC-41	COB	Added
Reason: New Job Title			
Program Manager	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Program Manager, Sr.	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Project Manager	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Project Manager II	OC-06	COB	Added
Reason: New Job Title			
Project Manager III	OC-06	COB	Added
Reason: New Job Title			
Project Manager IV	OC-06	COB	Added
Reason: New Job Title			
Project Manager, Lead	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Project Manager, Sr.	OC-41	COB	Deleted
Reason: Job Title Eliminated			
QI Nurse Specialist	OC-06	COB	Renamed, Category Changed
Reason: Revised Job Title, Disclosure Category Incorrect			
QI Nurse Specialist (LVN)	OC-06	COB	Added
Reason: Revised Job Title			
Records Manager	OC-06	COB	Unchanged

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Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Regulatory Affairs and Compliance Analyst	OC-41	COB	Unchanged
Regulatory Affairs and Compliance Analyst Sr.	OC-41	COB	Unchanged
Regulatory Affairs and Compliance Lead	OC-41	COB	Unchanged
RN (PACE)	OC-41	COB	Renamed
Reason: Revised job title			
Sr. Director	OC-01	COB	Unchanged
Sr. Manager I	OC-01	COB	Unchanged
Sr. Manager II	OC-01	COB	Unchanged
Sr. Manager III	OC-01	COB	Unchanged
Sr. Manager IV	OC-01	COB	Unchanged
Supervisor, Accounting	OC-01	COB	Unchanged
Supervisor, Audit and Oversight	OC-01	COB	Unchanged
Supervisor, Behavioral Health	OC-41	COB	Unchanged
Supervisor, Budgeting	OC-01	COB	Unchanged
Supervisor, Case Management	OC-41	COB	Unchanged
Supervisor, Claims	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Supervisor, Coding Initiatives	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Supervisor, Credentialing	OC-41	COB	Unchanged
Supervisor, Customer Service	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Supervisor, Data Entry	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Supervisor, Day Center (PACE)	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Supervisor, Dietary Services (PACE)	OC-41	COB	Unchanged
Supervisor, Encounters	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Supervisor, Facilities	OC-41	COB	Unchanged
Supervisor, Finance	OC-01	COB	Unchanged
Supervisor, Grievance & Appeals	OC-41	COB	Renamed
Reason: Revised job title			

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EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Supervisor, Information Technology Services	OC-08	COB	Unchanged
Supervisor, Long Term Support Services	OC-41	COB	Unchanged
Supervisor, Medical Assistant	OC-41	COB	Added
Reason: New Job Title			
Supervisor, Member Outreach and Education	OC-06	COB	Unchanged
Supervisor, MSSP	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Supervisor, Nursing Services (PACE)	OC-41	COB	Unchanged
Supervisor, OneCare Customer Service	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Supervisor, Payroll	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Supervisor, Pharmacist	OC-20	COB	Unchanged
Supervisor, Population Health Management	OC-41	COB	Renamed
Reason: Revised job title			
Supervisor, Provider Data Management Services	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Supervisor, Provider Relations	OC-41	COB	Unchanged
Supervisor, Quality Analytics	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			
Supervisor, Quality Improvement	OC-41	COB	Unchanged
Supervisor, Regulatory Affairs and Compliance	OC-41	COB	Unchanged
Supervisor, Social Work (PACE)	OC-41	COB	Unchanged
Supervisor, Therapy Services (PACE)	OC-41	COB	Unchanged
Supervisor, Utilization Management	OC-06	COB	Category Changed
Reason: Disclosure Category Incorrect			

Total: 163

OFFICIALS WHO ARE SPECIFIED IN GOVERNMENT CODE SECTION 87200

Officials who are specified in Government Code section 87200 (including officials who manage public investments, as defined by 2 Cal. Code of Regs. § 18700.3 (b)), are NOT subject to the Agency's Conflict of Interest Code, but are subject to the disclosure requirements of the Political Reform Act, Government Code section 87100, et seq. Gov't Code § 87203. These positions are listed here for informational purposes only.

The positions listed below are officials who are specified in Government Code section 87200:

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EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Alternate Member of the Board of Directors	Files with	COB	Unchanged
Chief Executive Officer	Files with	COB	Unchanged
Chief Financial Officer	Files with	COB	Unchanged
Member of the Board of Directors	Files with	COB	Unchanged

The disclosure requirements for these positions are set forth in Government Code section 87200, et. seq. They require the disclosure of interests in real property in the agency's jurisdiction, as well as investments, business positions and sources of income (including gifts, loans and travel payments).

Disclosure Descriptions
EXHIBIT B (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Disclosure Category	Disclosure Description	Status
87200 Filer	Form 87200 filers shall complete all schedules for Form 700 and disclose all reportable sources of income, interests in real property, investments and business positions in business entities, if applicable, pursuant to Government Code Section 87200 *et seq*..	Unchanged
OC-01	All interests in real property in Orange County, the authority or the District as applicable, as well as investments, business positions and sources of income (including gifts, loans and travel payments).	Unchanged
OC-06	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide leased facilities and goods, supplies, equipment, vehicles, machinery or services (including training and consulting services) of the types used by the County Department, Authority or District, as applicable.	Unchanged
OC-08	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that develop or provide computer hardware/software, voice data communications, or data processing goods, supplies, equipment, or services (including training and consulting services) used by the County Department, Authority or District, as applicable.	Unchanged
OC-11	All interests in real property in Orange County or located entirely or partly within the Authority or District boundaries as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that are engaged in the supply of equipment related to recruitment, employment search & marketing, classification, training, or negotiation with personnel; employee benefits, and health and welfare benefits.	Unchanged
OC-13	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that produce or provide promotional items for public outreach programs; present, facilitate, market or otherwise act as agent for media relations with regard to public relations; provide printing, copying, or mail services; or provide training for or development of customer service representatives.	Unchanged
OC-20	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide pharmaceutical services, supplies, materials or equipment.	Unchanged
OC-41	All interests in real property in Orange County, the District or Authority, as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide services, supplies, materials, machinery, vehicles, or equipment (including training and consulting services) used by the County Department, Authority or District, as applicable.	Unchanged

Grand Total: 8

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

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

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions
Approve amendments to the following operations policies and procedures:

1. Policy DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment; and

2. Policy EE.1101: Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory.

Background and Discussion
CalOptima Health is committed to ensuring its members have access to continuous care with their identified primary care physician. In line with this commitment, CalOptima Health proposes the below changes to the operational processes and associated plan when a primary care provider (PCP) requests to terminate from a CalOptima Health Community Network (CHCN). These changes are intended to improve member experience and support continuity of care and outcomes where members can maintain their established primary care physician. Additionally, this process will mitigate delays in patient care as a direct result of members having to establish a new patient-to-provider relationship due to the current PCP termination process.

Below is information regarding Operations policies that require modification:

1. **Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/ Assignment** describes the criteria by which a CHCN member shall select or be assigned to a PCP.

2. **Policy EE.1101 Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory** describes the criteria by which CalOptima Health processes additions, changes, or terminations of providers in the CalOptima Health directory and web-based directory.

Staff recommends the following updates to policies DD.2006b and EE.1101:
1. Policy DD.2006b
    - The proposed update will allow a PCP who terminates the contractual relationship with CHCN the option to notify CalOptima Health and request to continue providing care for the impacted members by designating another Health Network for those members.

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- Such request must be made at least 60 days in advance of the termination date; this is to allow sufficient time for member notification of the upcoming termination and member choice of a new PCP. In the absence of member choice, if the PCP requests to continue providing services to the impacted members, the members will be assigned to a Health Network designated by the PCP.

- This policy update also refers to Policy DD.2006 Enrollment In/Eligibility with CalOptima Health Direct, for the subset of members with specific health conditions who must remain with CHCN and will be assigned to a new PCP of the member's choice or another PCP in CHCN in the absence of member choice.

2. Policy EE.1101
   - The proposed updates define the timeframe the PCP will have to submit a request to maintain the relationship with the impacted members and requires the PCP to provide the name of the Health Network for member assignment.

   - The update also requires that the PCP have an active affiliation and open panel with the selected Health Network the members will be assigned to.

These policy changes will not impact the PCP termination process for all other Health Networks. Staff proposes to make these updates effective no sooner than January 1, 2025.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was included in the CalOptima Health Fiscal Year 2024-25 Operating Budget.

Rationale for Recommendation
The above recommended action will reinforce CalOptima Health's continued commitment to its members and their ability to maintain continuity of care with their chosen PCP.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Health Policy DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment
2. CalOptima Health Policy EE.1101 Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory

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Board Actions

Board Meeting Dates	Action
September 6, 2018	Authorize the Chief Executive Officer (CEO) to modify existing and develop new Policies and Procedures in conjunction with the Whole-Child Model initiative, as follows: 1. DD.2006: Enrollment In/ Eligibility with CalOptima [Medi-Cal] **2. DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/Assignment [Medi-Cal]** 3. EE.1112: Health Network Eligible Member Assignment to Primary Care Provider [Medi-Cal] 4. EE.1132: Bed Day Utilization Criteria for Physician Hospital Consortia [Medi-Cal] 5. GG.1401: Pharmacy Authorization Process [Medi-Cal] 6. GG.1409: Drug Formulary Development and Management [Medi-Cal] 7. GG.1410: Appeal Process for Pharmacy Authorization [Medi-Cal] 8. GG.1600: Access and Availability Standard [Medi-Cal] 9. GG.1650Δ: Credentialing and Recredentialing of Practitioners [All Lines of Business]
February 3, 2022	Approve the following actions related to CalOptima Provider Network policies: **1. Modifications to Policy EE.1101: Additions, Changes, and Terminations to CalOptima** Provider Information, CalOptima Provider Directory, and Web-based Directory; 2. Modifications to Policy EE.1103: Provider Network Training; 3. Retirement of Policy EE.1114: Health Network Notification of Change in Name, Management Company, Key Personnel, or Operating System; and 4. New Policy EE.1116: Contracted Provider Changes Affecting the Legal Status of the Contract; and 5. New Policy EE.1119: Health Network Notification of Administrative and Operational Changes

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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Policy:	DD.2006b
Title:	**CalOptima Health Community Network Member Primary Care Provider Selection/Assignment**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2011
Revised Date:	12/05/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the criteria by which a CalOptima Health Community Network (CHCN) Member shall select or be assigned a Primary Care Provider (PCP).

II. POLICY

A. CalOptima Health recognizes that it is in the best interest of a Member to establish a medical home and maintain continuity of care with a PCP.

B. As part of CalOptima Health's commitment to these objectives, a CHCN Member is encouraged to select a participating PCP in accordance with the terms and conditions of this policy. If a CHCN Member does not select a participating PCP, CalOptima Health shall assign the Member to a participating PCP in accordance with this policy.

C. CalOptima Health shall only assign a Member to a participating PCP who has been credentialed as a PCP by CalOptima Health.

D. A Member shall have the right to select a participating Community Health Center or Non-Physician Medical Practitioner as his or her PCP. If a Member chooses a participating Non-Physician Medical Practitioner as his or her PCP, the Member shall be assigned directly to the supervising physician and not the Non-Physician Medical Practitioner.

E. A Member categorized as a Senior or Person with a Disability (SPD) shall have the right to choose a PCP specialist physician who is a participating Provider, is willing to perform the role of the PCP, and has met CalOptima Health's requirements for a specialist to act as a PCP.

F. A Member eligible for the California Children's Services (CCS) Program, or the Member's parent(s), custodial parent(s), legal guardian(s), or other Authorized Representative(s), shall have the right to request a specialist as a PCP if the specialist agrees to serve in a PCP role and is a CCS-paneled Provider qualified to treat the required range of CCS-Eligible Conditions of the CCS child or youth, in accordance with CCS program rules and regulations.

G. CalOptima Health shall maintain the existing PCP assignment process for the Adult Expansion Population by designating a point of contact to coordinate with county uninsured programs and public health care systems to share data and use that data to effectuate PCP assignment.

1. CalOptima Health shall identify unique individuals in the county uninsured programs or public health care systems by Client Index Number (CIN). If the CIN is not available, other data elements shall be used such as name, date of birth, and address.

2. CalOptima Health shall send the Member PCP Assignment file with all the data elements outlined in the data transmission requirements, outlined in DHCS APL 23-031: Medi-Cal Managed Care Plan Implementation of Primary Care Provider Assignment for the Age 26-49 Adult Expansion Transition, to the county uninsured programs and public health care systems.

3. CalOptima Health shall receive data for the Adult Expansion Population from county uninsured programs and public health care systems to match PCP assignments for new and transitioning Members. CalOptima Health shall use the data elements provided to complete a Member match and PCP assignment.

4. CalOptima Health shall return the PCP Assignment Return File to the county uninsured programs and/or public health systems of the Members successfully assigned a PCP match.

5. CalOptima Health shall not preclude assignment based on a PCP having a closed panel or not accepting new Members.

6. CalOptima Health shall receive, store, use, or transmit PHI and share data, in accordance with CalOptima Health Policy HH.3023: Information Sharing.

7. CalOptima Health shall securely destroy data for individuals who do not ultimately enroll into CalOptima Health, in accordance with CalOptima Health Policy GA.3201: Document Management Program and with Health Insurance Portability and Accountability Act (HIPAA) regulations.

H. CalOptima Health shall make reasonable efforts to ensure that a Member expressing a desire to continue his or her existing relationship with a participating CHCN PCP is assigned to such PCP.

I. A Member who selects or is assigned to a participating Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as his or her PCP:

1. Shall be assigned directly to the FQHC or RHC; and

2. Shall not be assigned to an individual PCP performing services on behalf of the FQHC or RHC.

J. American Indian Members may choose an American Indian Health Care Provider within CalOptima Health's contracted network as his or her PCP.

K. CalOptima Health shall disclose to a Member the reason for which he or she could not select or be assigned to a specific PCP.

L. A Member may change his or her CHCN-participating PCP once every thirty (30) calendar days in accordance with this policy.

M. CalOptima Health shall notify the CHCN PCP via the provider portal that they have been selected by a Member, or that they have been assigned a Member by CalOptima Health, within ten (10) calendar days after completion of the selection or assignment.

N. ~~If CHCN terminates a participating PCP, or~~If a participating PCP terminates the contractual relationship with CHCN, CalOptima Health shall assign ~~a new CHCN participating PCP to an affected Member within seven (7) calendar days after the effective date of the termination. CalOptima Health shall make a good faith effort to give written notice of termination of a contracted Provider to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated Provider within fifteen (15) calendar days of receipt of termination notice and at least thirty (30) calendar days prior to the termination of the contract.~~impacted Members to a new PCP of the Member's choice. In the absence of Member choice, if the PCP requests to maintain the relationship with the Member, the Member shall be assigned to a Health Network of the PCP's choice.

1. Members diagnosed with the following conditions shall remain with CHCN and assigned to a new PCP of the Member's choice or auto assigned in the absence of Member choice:

   a. Diagnosed with hemophilia;

   b. A Member with a Breast and Cervical Cancer Treatment Program (BCCTP) Primary Aid Code;

   c. Listed for a Major Organ Transplant or approved for a Bone Marrow Transplant (BMT);

   d. Has received a Major Organ Transplant or BMT within one hundred twenty (120) calendar days prior to the Member's effective date of enrollment in CalOptima Health; or

   e. Is diagnosed with End Stage Renal Disease (ESRD).

O. CalOptima Health shall provide written notice of termination of a contracted Provider to each Member in accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services.

III. PROCEDURE

A. PCP Selection or Assignment for a Newly Enrolled CHCN Member

1. A newly eligible Member who chooses CHCN or is Auto-Assigned to CHCN shall have thirty (30) calendar days to select a CHCN participating PCP, or up to forty-five (45) calendar days if the Member's date of eligibility with CalOptima Health Direct (COHD) was after the fifteenth (15th) calendar day in the eligibility month~~, to select a CHCN participating PCP~~.

2. A Member assigned directly to CHCN, in accordance with CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct, shall be assigned a PCP in accordance with the terms of this policy.

3. If an Adult Expansion Population Member's PCP data is received from the county uninsured programs and public health care systems, CalOptima Health shall assign the member to the PCP listed in the PCP Assignment File.

4. If a Member does not select a participating PCP as described in Section III.A.1 of this Policy, or for a Member assigned directly to CHCN as described in Section III.A.2 of this Policy,

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CalOptima Health shall assign the Member to a participating PCP based on the following criteria:

a. If the Member was eligible with CalOptima Health within the last three hundred sixty-five (365) calendar days, CalOptima Health shall assign the Member to the last PCP on record that is currently a CHCN-participating PCP.

b. If the Member does not meet criteria outlined in Section III.A.~~3~~4.a and has a family Member in CHCN, CalOptima Health shall assign the Member to the same PCP, subject to any age and gender restrictions applicable to the PCP.

5. Notwithstanding the above, if an SPD or a CCS Member does not select a CHCN-participating PCP, CalOptima Health shall use Fee-For-Service (FFS) utilization data or other data sources (including electronic data), if available, for purposes of PCP assignment.

6. In the event Sections III.A.3-4 do not apply, CalOptima Health shall assign the Member to a participating PCP open for new assignment based on the following:

a. The geographic location of the participating PCP's office in relation to the Member's residence, in accordance with CalOptima Health Policy GG.1600: Access and Availability Standards;

b. The Member's language; then

c. The Member's age.

d. If more than one (1) PCP meets all assignment criteria, a PCP will be assigned based on a rotation to allow balanced distribution.

B. For a PCP who terminates from CHCN and requests to maintain the relationship with the Member;

1. The Provider shall submit a written request to CalOptima Health's Provider Relations Department at least sixty (60) calendar days prior to the expected date of termination including the Health Network name for Member assignment as appropriate.

2. CalOptima Health shall provide written notification to the Member in accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services.

3. In the absence of Member choice, CalOptima Health shall maintain the Member's relationship with the current PCP and the Health Network selected by the PCP.

4. The effective date of the change shall be the first (1st) of the month following the date of the PCP termination.

~~B.~~C. If a Member selects a participating PCP that is not accepting new Members, CalOptima Health shall:

1. Inform the Member to choose a participating PCP to avoid Auto-Assignment.

2. Contact the PCP, if a Member contacts CalOptima Health and indicates an existing relationship with a participating PCP not accepting new Members and make all reasonable efforts to ensure that the Member may continue an existing relationship with the participating PCP.

3. Assign the Member to a CHCN-participating PCP, in accordance with Section III.A. of this policy, if CalOptima Health is unable to obtain a CHCN-participating PCP from the Member.

~~C.~~D. A Member may request to change his or her participating PCP every thirty (30) calendar days by contacting CalOptima Health's Customer Service Department.

1. If the Member requests a PCP change before seeing his or her assigned PCP prior to the sixteenth (16th) calendar day of the current month, CalOptima Health shall make the change effective the first (1st) calendar day of the current month.

2. If the Member requests a PCP change after seeing his or her assigned PCP after the sixteenth (16th) calendar day of the current month, CalOptima Health shall make the change effective the first (1st) calendar day of the immediately following month.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Community Network (CHCN) Primary Care Provider (PCP) Selection Form and Guide
B. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health Contract for Health Care Services
D. CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct
E. CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services
~~E.~~F. CalOptima Health Policy GA.3201: Document Management Program
~~F.~~G. CalOptima Health Policy GG.1600: Access and Availability Standards
~~G.~~H. CalOptima Health Policy HH.3023: Information Sharing
~~H.~~I. Department of Health Care Services All Plan Letter (APL) 23-031: Medi-Cal Managed Care Plan Implementation of Primary Care Provider Assignment for the Age 26-49 Adult Expansion Transition
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~~K.~~L. Title 22, California Code of Regulations (CCR), §55170
~~L.~~M. Title 42, Code of Federal Regulations (CFR), §438.10(f)(5)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/12/2010	Department of Health Care Services (DHCS)	Approved as Submitted
04/07/2015	Department of Health Care Services (DHCS)	Approved as Submitted
10/09/2017	Department of Health Care Services (DHCS)	Approved as Submitted
09/17/2018	Department of Health Care Services (DHCS)	Approved as Submitted
06/05/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/16/2024	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting

11/05/2009	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2011	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	03/01/2011	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	07/01/2011	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
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Revised	09/01/2022	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	05/01/2023	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	04/01/2024	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	12/05/2024	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal

IX. GLOSSARY

Term	Definition
Adult Expansion Population	An expansion population as defined by amended Welfare and Institutions Code (W&I) Section 14007.8 for full scope Medi-Cal to individuals who are twenty-six (26) through forty-nine (49) years of age, and who do not have satisfactory immigration status (SIS) as required by W&I Section 14011.2.
Authorized Representative	Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Auto-Assignment	The process by which a CalOptima Health Member who does not select a PCP and/or Health Network is assigned to a participating CalOptima Health Provider and/or Health Network.
California Children's Services (CCS)-Eligible Condition	A medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 et seq.
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CalOptima Health Direct (COHD) Member	~~A Member who receives all Covered Services through CalOptima Health Direct.~~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.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network; and 3. Ability to function as a Primary Care Provider (PCP).
Covered Services	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, this Contract, and APLs that are made the responsibility of Contractor 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 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

Term	Definition
	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 this Contract, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than 21 years of age. Contractor 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); 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, Contractor 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, Contractor 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 21 years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM

Term	Definition
	services, Contractor must ensure access to comparable services under the EPSDT benefit in accordance with 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 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 APL 22-012.
Federally Qualified Health Center (FQHC)	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).
Member	For the purposes of this policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal, or the United States Social Security Administration, who is enrolled in the CalOptima Health program and the CalOptima Health Community Network.
Non-Physician Medical Practitioner	A nurse midwife, physician's assistant, or nurse practitioner who provides primary care.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Rural Health Clinic (RHC)	An entity defined in Title 22 CCR Section 51115.5.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.

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Policy:	DD.2006b
Title:	**CalOptima Health Community Network Member Primary Care Provider Selection/Assignment**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2011
Revised Date:	12/05/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the criteria by which a CalOptima Health Community Network (CHCN) Member shall select or be assigned a Primary Care Provider (PCP).

II. POLICY

A. CalOptima Health recognizes that it is in the best interest of a Member to establish a medical home and maintain continuity of care with a PCP.

B. As part of CalOptima Health's commitment to these objectives, a CHCN Member is encouraged to select a participating PCP in accordance with the terms and conditions of this policy. If a CHCN Member does not select a participating PCP, CalOptima Health shall assign the Member to a participating PCP in accordance with this policy.

C. CalOptima Health shall only assign a Member to a participating PCP who has been credentialed as a PCP by CalOptima Health.

D. A Member shall have the right to select a participating Community Health Center or Non-Physician Medical Practitioner as his or her PCP. If a Member chooses a participating Non-Physician Medical Practitioner as his or her PCP, the Member shall be assigned directly to the supervising physician and not the Non-Physician Medical Practitioner.

E. A Member categorized as a Senior or Person with a Disability (SPD) shall have the right to choose a PCP specialist physician who is a participating Provider, is willing to perform the role of the PCP, and has met CalOptima Health's requirements for a specialist to act as a PCP.

F. A Member eligible for the California Children's Services (CCS) Program, or the Member's parent(s), custodial parent(s), legal guardian(s), or other Authorized Representative(s), shall have the right to request a specialist as a PCP if the specialist agrees to serve in a PCP role and is a CCS-paneled Provider qualified to treat the required range of CCS-Eligible Conditions of the CCS child or youth, in accordance with CCS program rules and regulations.

G. CalOptima Health shall maintain the existing PCP assignment process for the Adult Expansion Population by designating a point of contact to coordinate with county uninsured programs and public health care systems to share data and use that data to effectuate PCP assignment.

1. CalOptima Health shall identify unique individuals in the county uninsured programs or public health care systems by Client Index Number (CIN). If the CIN is not available, other data elements shall be used such as name, date of birth, and address.

2. CalOptima Health shall send the Member PCP Assignment file with all the data elements outlined in the data transmission requirements, outlined in DHCS APL 23-031: Medi-Cal Managed Care Plan Implementation of Primary Care Provider Assignment for the Age 26-49 Adult Expansion Transition, to the county uninsured programs and public health care systems.

3. CalOptima Health shall receive data for the Adult Expansion Population from county uninsured programs and public health care systems to match PCP assignments for new and transitioning Members. CalOptima Health shall use the data elements provided to complete a Member match and PCP assignment.

4. CalOptima Health shall return the PCP Assignment Return File to the county uninsured programs and/or public health systems of the Members successfully assigned a PCP match.

5. CalOptima Health shall not preclude assignment based on a PCP having a closed panel or not accepting new Members.

6. CalOptima Health shall receive, store, use, or transmit PHI and share data, in accordance with CalOptima Health Policy HH.3023: Information Sharing.

7. CalOptima Health shall securely destroy data for individuals who do not ultimately enroll into CalOptima Health, in accordance with CalOptima Health Policy GA.3201: Document Management Program and with Health Insurance Portability and Accountability Act (HIPAA) regulations.

H. CalOptima Health shall make reasonable efforts to ensure that a Member expressing a desire to continue his or her existing relationship with a participating CHCN PCP is assigned to such PCP.

I. A Member who selects or is assigned to a participating Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as his or her PCP:

1. Shall be assigned directly to the FQHC or RHC; and

2. Shall not be assigned to an individual PCP performing services on behalf of the FQHC or RHC.

J. American Indian Members may choose an American Indian Health Care Provider within CalOptima Health's contracted network as his or her PCP.

K. CalOptima Health shall disclose to a Member the reason for which he or she could not select or be assigned to a specific PCP.

L. A Member may change his or her CHCN-participating PCP once every thirty (30) calendar days in accordance with this policy.

M. CalOptima Health shall notify the CHCN PCP via the provider portal that they have been selected by a Member, or that they have been assigned a Member by CalOptima Health, within ten (10) calendar days after completion of the selection or assignment.

N. If a participating PCP terminates the contractual relationship with CHCN, CalOptima Health shall assign impacted Members to a new PCP of the Member's choice. In the absence of Member choice, if the PCP requests to maintain the relationship with the Member, the Member shall be assigned to a Health Network of the PCP's choice.

1. Members diagnosed with the following conditions shall remain with CHCN and assigned to a new PCP of the Member's choice or auto assigned in the absence of Member choice:

a. Diagnosed with hemophilia;

b. A Member with a Breast and Cervical Cancer Treatment Program (BCCTP) Primary Aid Code;

c. Listed for a Major Organ Transplant or approved for a Bone Marrow Transplant (BMT);

d. Has received a Major Organ Transplant or BMT within one hundred twenty (120) calendar days prior to the Member's effective date of enrollment in CalOptima Health; or

e. Is diagnosed with End Stage Renal Disease (ESRD).

O. CalOptima Health shall provide written notice of termination of a contracted Provider to each Member in accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services.

III. PROCEDURE

A. PCP Selection or Assignment for a Newly Enrolled CHCN Member

1. A newly eligible Member who chooses CHCN or is Auto-Assigned to CHCN shall have thirty (30) calendar days to select a CHCN participating PCP, or up to forty-five (45) calendar days if the Member's date of eligibility with CalOptima Health Direct (COHD) was after the fifteenth (15th) calendar day in the eligibility month.

2. A Member assigned directly to CHCN, in accordance with CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct, shall be assigned a PCP in accordance with the terms of this policy.

3. If an Adult Expansion Population Member's PCP data is received from the county uninsured programs and public health care systems, CalOptima Health shall assign the member to the PCP listed in the PCP Assignment File.

4. If a Member does not select a participating PCP as described in Section III.A.1 of this Policy, or for a Member assigned directly to CHCN as described in Section III.A.2 of this Policy, CalOptima Health shall assign the Member to a participating PCP based on the following criteria:

a. If the Member was eligible with CalOptima Health within the last three hundred sixty-five (365) calendar days, CalOptima Health shall assign the Member to the last PCP on record that is currently a CHCN-participating PCP.

b. If the Member does not meet criteria outlined in Section III.A.4.a and has a family Member in CHCN, CalOptima Health shall assign the Member to the same PCP, subject to any age and gender restrictions applicable to the PCP.

5. Notwithstanding the above, if an SPD or a CCS Member does not select a CHCN-participating PCP, CalOptima Health shall use Fee-For-Service (FFS) utilization data or other data sources (including electronic data), if available, for purposes of PCP assignment.

6. In the event Sections III.A.3-4 do not apply, CalOptima Health shall assign the Member to a participating PCP open for new assignment based on the following:

   a. The geographic location of the participating PCP's office in relation to the Member's residence, in accordance with CalOptima Health Policy GG.1600: Access and Availability Standards;

   b. The Member's language; then

   c. The Member's age.

   d. If more than one (1) PCP meets all assignment criteria, a PCP will be assigned based on a rotation to allow balanced distribution.

B. For a PCP who terminates from CHCN and requests to maintain the relationship with the Member;

1. The Provider shall submit a written request to CalOptima Health's Provider Relations Department at least sixty (60) calendar days prior to the expected date of termination including the Health Network name for Member assignment as appropriate.

2. CalOptima Health shall provide written notification to the Member in accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services.

3. In the absence of Member choice, CalOptima Health shall maintain the Member's relationship with the current PCP and the Health Network selected by the PCP.

4. The effective date of the change shall be the first (1st) of the month following the date of the PCP termination.

C. If a Member selects a participating PCP that is not accepting new Members, CalOptima Health shall:

1. Inform the Member to choose a participating PCP to avoid Auto-Assignment.

2. Contact the PCP, if a Member contacts CalOptima Health and indicates an existing relationship with a participating PCP not accepting new Members and make all reasonable efforts to ensure that the Member may continue an existing relationship with the participating PCP.

3. Assign the Member to a CHCN-participating PCP, in accordance with Section III.A. of this policy, if CalOptima Health is unable to obtain a CHCN-participating PCP from the Member.

D. A Member may request to change his or her participating PCP every thirty (30) calendar days by contacting CalOptima Health's Customer Service Department.

1. If the Member requests a PCP change before seeing his or her assigned PCP prior to the sixteenth (16th) calendar day of the current month, CalOptima Health shall make the change effective the first (1st) calendar day of the current month.

2. If the Member requests a PCP change after seeing his or her assigned PCP after the sixteenth (16th) calendar day of the current month, CalOptima Health shall make the change effective the first (1st) calendar day of the immediately following month.

IV. ATTACHMENT(S)

Not Applicable

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Covered Services	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, this Contract, and APLs that are made the responsibility of Contractor 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 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)

Term	Definition
	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 this Contract, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than 21 years of age. Contractor 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); 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, Contractor 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, Contractor 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 21 years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, Contractor must ensure access to comparable services under the EPSDT benefit in accordance with APL 23-005;

Term	Definition
	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 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 APL 22-012.
Federally Qualified Health Center (FQHC)	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).
Member	For the purposes of this policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal, or the United States Social Security Administration, who is enrolled in the CalOptima Health program and the CalOptima Health Community Network.
Non-Physician Medical Practitioner	A nurse midwife, physician's assistant, or nurse practitioner who provides primary care.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Rural Health Clinic (RHC)	An entity defined in Title 22 CCR Section 51115.5.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.

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Policy:	EE.1101
Title:	**Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory**
Department:	Provider Network Operations
Section:	Provider Data Management Services
CEO Approval:	*/s/*
Effective Date:	11/01/1995
Revised Date:	12/05/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process for adding, changing, or terminating a Provider in the CalOptima Health Provider Directory and Web-based Directory.

II. POLICY

A. For each CalOptima Health program, CalOptima Health shall publish a printed hardcopy and online PDF version of the Provider Directory on a monthly basis, and a Web-based Directory that is updated within forty-eight (48) hours of an Addition, Change, or Termination of a Provider.

B. The Provider Directory shall include information on Health Networks, hospitals, Primary Care Providers (PCPs), OB/GYNs, specialists, behavioral health Providers, managed long-term services and support (MLTSS) Providers, urgent care centers, ancillary Providers, Facilities, and pharmacies who are credentialed and contracted with CalOptima Health directly or through a subcontracted agreement with a Health Network.

C. CalOptima Health shall ensure the printed hardcopy and online PDF version of the Provider Directory address Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) requirements for Provider Directories.

D. CalOptima Health shall submit the Medi-Cal Provider Directory to DHCS every six (6) months and shall include a PDF with the submission which DHCS can use for distribution, as needed.

1. CalOptima Health shall submit the Medi-Cal Provider Directory to DHCS on a monthly basis.

2. CalOptima Health shall address any findings during DHCS' Provider Directory reviews or medial audits within the timeframe specified by DHCS.

E. CalOptima Health shall update the Medi-Cal Provider Directory Application Programming Interface (API) in accordance with 42 CFR section 438.10(h)(3) and Health and Safety Code section 1367.27 and as outlined in Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: ~~Inoperability~~Interoperability and Patient Access Final Rule.

1. CalOptima Health and Health Networks shall conduct routine testing, monitoring, and system updates to ensure APIs function properly.

2. CalOptima Health and Health Networks shall attest to meeting all Provider Directory API requirements and shall submit attestation as outlined in Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: ~~Inoperability~~ Interoperability and Patient Access Final Rule.

3. CalOptima Health and Health Networks shall reserve the right to deny or discontinue any third-party application's connections to an API if it is reasonably determined, consistent with the security risk analysis under the HIPAA Security Rule, that continued access presents an unacceptable risk to the security of PHI on CalOptima Health's systems.

   a. CalOptima Health's determination to deny or discontinue any third-party application's connection to an API shall be made using objective verifiable criteria that is applied fairly and consistently across all applications and developers.

4. CalOptima Health and Health Networks shall demonstrate to DHCS their ability to comply with ~~inoperability~~interoperability requirements by submitting readiness, implementation and ongoing deliverables as directed by DHCS.

F. CalOptima Health and Health Networks shall report changes to information for a Provider or Facility in the CalOptima Health Provider Directory and Web-based Directory on an ongoing basis in accordance with this Policy.

G. CalOptima Health, Health Networks, Delegated Provider Groups, and Providers shall validate their directory information on a semi-annual basis in accordance with this Policy.

H. CalOptima Health shall require its contracted Providers be enrolled as Medi-Cal Providers, in accordance with DHCS APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment if there exists a state-level enrollment pathway.

I. CalOptima Health shall ensure the Web-based Provider Directory is made available in a machine-readable file and format, with search functionality in accordance with Title 42 of the Code of Federal Regulations, section 438.10(h)(4), and section 1367.27(c)(2) of the California Health and Safety Code.

III. PROCEDURE

A. CalOptima Health shall publish a Provider Directory for each CalOptima Health program and a Web-based Directory that includes, but is not limited to, the following information to help existing and prospective Members choose physicians:

1. Headers to indicate city or region names (in alphabetical order);

2. Name;

3. Gender;

4. Specialty;

5. Taxonomy (primary, secondary, tertiary) (See Attachment C: NUCC Taxonomy Code List);

6. Area of focus, if applicable;

7. National Provider Identifier (NPI);

8. Hospital affiliation(s);

9. Primary care clinic or Medical Group affiliations, if applicable;

10. Board certification, if applicable;

11. Age limits (Member age minimum, Member age maximum, gender restrictions);

12. Listing of languages spoken by the Provider, including American Sign Language;

13. Listing of languages spoken by clinical staff;

14. Telehealth Provider indicators:

    a. Only Telehealth;

    b. No Telehealth (only in-person); or

    c. Both Telehealth and in-person;

15. Telehealth site indicators:

    a. Only Telehealth;

    b. No Telehealth (only in-person); or

    c. Both Telehealth and in-person;

16. Practice address (including suite number);

17. City;

18. State;

19. Zip code;

20. Telephone number including area code;

21. Proximity to public transportation;

22. After-hours telephone number;

23. Office days and hours;

24. California license number and type of license;

25. Web site URL, if applicable;

26. Public email address, if available and attestation is obtained;

27. Administrative email address;

28. Facility physical accessibility compliance (OSHA);

29. Provider type;

30. CalOptima Health program(s) (Medi-Cal and/or Medicare);

31. Tier, if applicable;

32. Health Network affiliation;

33. Facility affiliations (hospital name);

34. Hospital admitting privileges;

35. An individual Provider's panel status is at least one (1) of the following:

    a. Accepting new Members;

    b. Accepting existing Members;

    c. Available by referral only;

    d. Available only through a hospital or Facility;

    e. Not accepting new patients; or

    f. Accepting new and existing patients;

36. Special services, panel status, or certification such as California Children's Services (CCS) and expiration; and

37. Supervising Physician full name and license number for mid-level Providers, when applicable.

B. CalOptima Health's Provider and Web-based Directories shall include:

1. All Providers who contract with a Health Network and CalOptima Health Community Network (CHCN) to deliver health care services to Members including, but not limited to:

    a. Physicians and surgeons;

    b. Indian Health Care Providers (IHCPs), nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, Doulas, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service Providers, nurse midwives, and dentists;

c. Federally Qualified Health Centers (FQHCs), Indian Health Facilities (IHF), Rural Health Clinics (RHCs), and primary care clinics to the extent they are available in CalOptima Health service area;

d. Health Home Program Providers;

e. Facilities, including but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities; and

f. Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.

2. Identification of Providers that are not available to all or new Members.

3. Instructions and information on how to use the Directory. The instructions shall describe and explain any acronyms and symbols used within the Provider Directory, information on how to use CalOptima Health services, and who to call for assistance.

   a. The Directory shall be available in threshold languages, in accordance with CalOptima Health Policies DD.2002: Cultural and Linguistic Services., and PA.1007: Delivery of PACE Services.

4. A statement informing Members that they are entitled to language interpreter services at no cost, including contact information on how to obtain language services.

5. Instructions on how to contact CalOptima Health if the Provider Directory information appears to be inaccurate.

6. Instructions on how to contact the Department of Health Care Services (DHCS) Medi-Cal Managed Care Office of the Ombudsman if the Provider Directory information appears to be inaccurate.

7. Instructions advising Members to contact Customer Service to verify the availability of selected Providers or to request additional information, such as Provider race/ethnicity data, physician education and training, and other relevant details as required by Member Experience (ME) 2, Element A, Factor 7 of the 2024 Health Plan (HP) Standards and Guidelines.

8. A disclosure statement assuring Members of full and equal access to Covered Services, regardless of disability status.

9. A listing of the physical accessibility indicators with the accessibility symbol listed before the word "Accessibility" pursuant to DHCS guidance and CalOptima Health Policy GG.1608: Full Scope Site Reviews.

C. Health Networks, CHCN, Delegated Provider Groups, or a Provider (as applicable) shall submit to the Provider Data Management Services (PDMS) Department a written request to add, change, or terminate a Provider from the CalOptima Health Provider Directory or Web-based Directory as follows:

1. Provider Additions: Minimum of thirty (30) calendar days advanced written notice;

2. Provider Changes: Minimum of thirty (30) calendar days advanced written notice; and

3. Provider Terminations: Minimum of ninety (90) calendar days advanced written notice in accordance with CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

D. On a semi-annual basis, a Health Network and CHCN will require contracted Providers to confirm that their information in the Provider Directory is accurate and/or update the information, if applicable.

E. CalOptima Health shall maintain a process and system by which Providers may submit verification or changes to their listed information in the Provider Directory in a manner consistent with guidance from the DHCS and applicable contractual obligations.

F. CalOptima shall maintain a process to continuously validate provider's Medi-Cal Enrollment status consistent with DHCS APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment if there is a state-level enrollment pathway.

G. Health Network, CHCN, Delegated Provider Group, or Provider Request to Add a Provider

1. CalOptima Health's PDMS Department shall add a Health Network, Delegated Provider Group and/or CHCN Provider to the system of record within five (5) business days of submission based on the effective date indicated on the CalOptima Health Add/Change/Term (ACT) form (Attachment A) or electronic notification (with applicable data) for inclusion in the Provider Directory and Web-based Directory. CalOptima Health requires its Health Networks, subdelegates, Delegated Provider Groups, Providers and practitioners to promptly inform CalOptima Health of any changes to information regarding Provider demographics, credentialing, panel status, and other information requested on the CalOptima Health ACT form (Attachment A) or electronic notification (with applicable data) to ensure data accuracy, integrity and to audit/confirm the information provided by its Providers is true and correct.

2. A Health Network, CHCN, Delegated Provider Group, or Provider add request shall include:

a. CalOptima Health (ACT) form (Attachment A) (recommended) or electronic notification with applicable data;

b. Signed W9 form;

c. Health Network contract front and signature page (if applicable);

d. Provider Profile: a complete Provider profile that includes the following information:

i. Legal, full name of the Provider, as shown on his or her medical license;

ii. Program information (contracted CalOptima Health programs) and effective date;

iii. Gender;

iv. Primary, secondary, and tertiary specialty, as applicable;

v. Board certified specialty, if applicable;

vi. Taxonomy (primary, secondary, tertiary) (See Attachment C: NUCC Taxonomy Code List);

vii. Area of focus, if applicable;

viii. Type 1 (individual) NPI and Type 2 (organizations) NPI, if applicable;

ix. State license number;

x. Address, phone and facsimile number for the Provider service location;

xi. Days and hours of operation;

xii. Hospital affiliation(s);

xiii. Accepting new patients;

xiv. Accepting existing Members;

xv. Available by referral only;

xvi. Available only through a hospital or Facility; or

xvii. Not accepting new patients;

xviii. Accepting new and existing patients

xix. Age limits (member age minimum, member age maximum, gender restrictions);

xx. Languages spoken by the physician including American Sign Language;

xxi. Languages spoken by clinical staff;

xxii. Telehealth Provider indicators:

a) Only Telehealth;

b) No Telehealth (only in-person); or

c) Both telehealth and in-person.

xxiii. Telehealth site indicators:

a) Only Telehealth;

b) No Telehealth (only in-person); or

c) Both telehealth and in-person;

xxiv. Medi-Cal enrolled (Y/N) and effective date;

xxv. Medicare enrolled (Y/N); and

xxvi. A copy of the "Provider Directory Listing Authorization" section of the physician profile for mid-level practitioners, when applicable.

e. For Facilities, a complete Facility profile that includes the following information:

i. Facility name;

ii. Location;

iii. Accreditation;

iv. Phone number;

v. NPI;

vi. Languages spoken at Facility; and

vii. Telehealth indicator, site location.

3. A Health Network, CHCN, Delegated Provider Group, or Provider shall submit a request to the PDMS Department by one (1) of the following methods:

a. E-mail to ProviderOnline@caloptima.org; or

b. Fax to 714-954-2330.

4. If discrepancies are identified, the PDMS department shall reject and return the request to the requesting Health Networks, CHCN, Delegated Provider Group, or Provider for clarification within five (5) business days. Once the discrepancies are resolved, the corrected information must be resubmitted to the PDMS Department within five (5) business days.

5. The PDMS Department shall update the Provider or Facility file(s) in the Provider information system and, subsequently, the Web-based Directory, within five (5) business days of receipt of completed information.

6. The PDMS department shall ensure provider NPIs are validated and added to the 274 Network Provider File, including but not limited to PCPs, Specialists, and Dyadic Care Services.

H. Health Network, CHCN, Delegated Provider Group, or Provider Request to Change demographic or other information for a Provider, Practitioner or Facility.

1. CalOptima Health's PDMS Department shall update demographic or other information in the system of record within five (5) business days of submission based on the effective date indicated on the CalOptima Health Add/Change/Term (ACT) form (Attachment A) or electronic notification (with applicable data) for inclusion in the Provider Directory and Web-based Directory. A Health Network, CHCN, Delegated Provider Group, or Provider change request shall include:

a. Legal, full name of the practitioner, as shown on his or her medical license;

b. Program information (contracted CalOptima Health programs) and effective date;

c. Primary, secondary, and tertiary specialty, as applicable;

d. Board certified specialty, if applicable;

e. Taxonomy (primary, secondary, tertiary) (See Attachment C: NUCC Taxonomy Code List);

f. Type 1 (individual) NPI and Type 2 (organizations) NPI, if applicable;

g. Tax identification number (TIN);

h. State license number;

i. Gender;

j. Address, telephone and facsimile number for the Provider service location, including a telephone number for after normal business hours, if applicable;

k. Days and hours of operation;

l. Hospital affiliation;

m. Accepting new patients;

n. Age limits (Member age minimum, Member age maximum, gender restrictions);

o. Languages spoken by the physician including American Sign Language;

p. Languages spoken by clinical staff;

q. Telehealth Provider indicators:

   i. Only Telehealth;

   ii. No Telehealth (only in-person); or

   iii. Both telehealth and in-person;

r. Telehealth site indicators:

   i. Only Telehealth;

   ii. No Telehealth (only in-person); or

   iii. Both telehealth and in-person;

s. Medi-Cal enrolled (Y/N) and effective date; and

t. Medicare enrolled (Y/N).

2. A Health Network, CHCN, Delegated Provider Group, or Provider shall submit requests for Provider changes to the PDMS Department by one (1) of the following methods:

   a. E-mail to: ProviderOnline@CalOptima.org; or

   b. Fax to: 714-954-2330.

3. If discrepancies are identified, the PDMS department shall return the profile to the requesting Health Networks, CHCN, Delegated Provider Group or Provider for clarification within five (5) business days. Once the discrepancies are resolved, the corrected information must be resubmitted to the PDMS Department within five (5) business days.

4. The PDMS Department shall update the Provider or Facility file(s) in the provider information system and the web-based directory within thirty (30) calendar days of receipt of completed information.

I. Health Network, CHCN, Delegated Provider Group, or Provider Request to Terminate a Provider or Facility:

1. CalOptima Health 's PDMS Department shall terminate a Provider or Facility in the system of record within five (5) business days of submission based on the termination date indicated on the CalOptima Health ACT form (Attachment A) or electronic notification (with applicable data) ~~for inclusion~~ for inclusion in the Provider Directory and Web-based Directory. A Health Network, CHCN, Delegated Provider Group, or Provider termination request shall include:

   a. A copy of the Provider or Facility termination notice with the effective date for termination.

   b. For a PCP who terminates from CHCN and requests to maintain the relationship with the Member:

      i. The Provider shall submit a written request to CalOptima Health's Provider Relations Department at least sixty (60) calendar days prior to the expected date of termination including the Health Network name for Member assignment as appropriate.

      ii. The PCP must have an active affiliation and their panel status "open" with the selected Health Network the Members are being assigned to.

2. For terminating Providers, CalOptima Health or the Health Network shall notify affected Members and DHCS, as applicable, in accordance with CalOptima Health ~~Policies~~Policies DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment, DD.2008: Health Network Selection Process, DD.2012: Member Notification of Change in the Availability or Location of Covered Services, MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification, and GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services. The PDMS Department shall notify Customer Service of Provider termination for purpose of Member notification and re-assignment of Members.

J. On a weekly basis, the PDMS Department shall send to the Health Networks and CHCN Provider, Practitioner and Facility reports of Additions, Changes, and Terminations for review of accuracy.

1. If discrepancies are identified on any Provider files, Health Networks and CHCN shall address the discrepancies.

a. Upon addressing discrepancies, the Health Network or CHCN shall notify the PDMS Department.

b. The PDMS Department shall update the Provider, practitioner and Facility files within five (5) business days in the provider information system and shall update the Web-based Directory.

K. On a monthly basis, CalOptima Health shall obtain an electronic update from the National Committee on Quality Assurance (NCQA) regarding providers who achieve Patient-Centered Medical Home (PCMH) recognition status. The updates from NCQA shall be seen on the Web-based Directory within ten (10) calendar days after receipt of the data file from NCQA.

L. Verification of Provider Information

1. CalOptima Health and Health Networks shall verify and update all information outlined in Section III.A. of this Policy to ensure accuracy of the information listed in the Provider Directory and Web-based Directory. CalOptima Health and Health Networks shall notify contracted Providers of the requirement to maintain and attest to the accuracy of Provider Directory information.

a. Notification

i. On a semi-annual basis, CalOptima Health shall notify and instruct Providers of the process to verify or update information listed in the Provider Directory and Web-based Directory, in a manner consistent with guidance from DHCS and applicable contractual obligations.

b. Verification

i. On a semi-annual basis, CalOptima Health shall distribute a Provider Data Universe to Health Networks and CHCN in the first (1st) and third (3rd) quarter of each calendar year.

ii. Health Networks and CHCN shall conduct validation of all information listed in the Provider Data Universe in accordance with this Policy.

iii. Health Networks and CHCN shall document the outcome of each attempt to verify Provider information.

iv. If through this process, a Health Network or CHCN discovers a Provider has retired, ceased practicing, or if the Provider is no longer affiliated with a practice, CalOptima Health shall remove the Provider from the Provider Directory in accordance with Section III.H. of this Policy.

c. Provider Directory Validation Attestation

i. Health Networks and CHCN shall require contracted Providers to validate and attest in writing to the accuracy of their Provider Directory information.

ii. If a Provider fails to respond to the request for validation and written attestation within thirty (30) business days, Health Networks and CHCN shall attempt to verify if the Provider information is accurate or requires updating within fifteen (15) business days.

iii. If a Health Network~~s~~ or CHCN is unable to verify whether the Provider's information is accurate or requires updating, a notice shall be sent to the Provider informing them of the intent to remove them from the Provider Directory for failure to submit appropriate validation and written attestation in accordance with this Policy.

a) Health Networks and CHCN shall notify Providers ten (10) business days prior to removal from the Provider Directory.

i) Providers that fail to respond will be removed from the Provider Directory in accordance with Section III.H. of this Policy.

ii) Providers will not be removed from the Provider Directory if a response is received before the end of the tenth (10th) business day.

iv. A Provider's failure to validate and attest to the accuracy of their Provider Directory data may result in panel closure, suppression from the Provider Directory, and/or delay of payment.

v. General acute care hospitals shall not be required to provide a response.

d. Collection and Submission of Provider Attestation

i. Health Networks and CHCN shall collect written Provider attestations from all contracted Providers for annual submission to the CalOptima Health Audit and Oversight Department.

ii. Health Networks and CHCN shall submit written Provider attestations, as requested by CalOptima Health 's Audit and Oversight department, in the fourth (4th) quarter of each calendar year.

iii. Written Provider attestations must be stored electronically for a minimum of ten (10) years.

M. Access to CalOptima Health Provider Directory and Web-based Directory

1. CalOptima Health shall provide Members, prospective Members, Providers and members of the public information from the CalOptima Health Provider Directory and Web-based Directory in alternate media formats. Alternate media formats include:

a. Print

i. CalOptima Health staff shall send by U.S. Postal Service mail to new Members the CalOptima Health Provider Directory upon enrollment in the CalOptima Health program or by request, postmarked no later than five (5) business days following the date of the request and in accordance with CalOptima Health Policy DD.2008: Health Network Selection Process; or

b. Telephone

i. CalOptima Health staff shall utilize the Web-based Directory to assist Members over the phone in finding a Provider. If a Member requests Provider information or the CalOptima Health Provider Directory, CalOptima Health staff shall print and send the requested information to the Member by U.S. mail.

N. CalOptima Health shall review its Web-based Directory for usability every three (3) years. Review shall include, but is not limited to:

1. Font size;

2. Reading level;

3. Ease of navigation;

4. Intuitive content organization; and

5. Directories in different languages.

O. Validation of Web-based Directory

1. A Health Network and CHCN shall validate the Web-based Directory Provider, Practitioner and Facility information at least annually. Validation shall consist of the following:

a. Data sources, and

b. Limitations for each item of information on the Web-based Directory.

2. Web-based Directory Provider, Practitioner and Facility validation and frequency table:

	Provider Definition	**Information Collection and Validation**
Name	The alternative name preferred by and as specified by the practitioner, provider, or Facility which may be familiar to patients and can be published on provider directory.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Provider Type	Includes: Physicians and surgeons; Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, nurse midwives, and dentists;	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

	Provider Definition	Information Collection and Validation
	Federally Qualified Health Centers (FQHCs) or primary care clinics; Facilities, including but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities; and Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.	
License Number	California license number of the practitioner. Catenate the license type letter (NP, CNM, and PA for mid-level; A, C, G, and 20A for MD and DO; E for DPM) and license number together and no space in between.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
NPI	National provider identifier of the practitioner (NPI type 1, 10 digits) National provider identifier of the hospital (NPI type 2, 10 digits)	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Gender	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice Address	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice City	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice State	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice Zip Code	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Phone Number	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between the validation time frames.

	Provider Definition	Information Collection and Validation
After Hours Phone Number	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Age Limits	Member age minimum, member age maximum and gender restriction.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Specialty	The clinical area in which the CalOptima Health contracted physician received specialized training, such as a residency or fellowship.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Taxonomy (primary, secondary, tertiary)	The taxonomy code of the specialty for which the practitioner has.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Area of Focus	The specific focus of the specialty for which the practitioner has.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Facility Hospital Affiliations (Hospital Name)	The name of CalOptima Health contracted hospital where the practitioner him/herself is on staff and/or having admitting privilege.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames
Hospital Admitting Privileges	Includes: Active, Provisional, Courtesy, Surgical, Consultant, Suspended, Limited, Associate Staff, Honorary Staff, and Senior Attending.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

	Provider Definition	Information Collection and Validation
Board Certification	When a health care practitioner is board certified, it means that he or she has applied for and been awarded certification from the American Board of Medical Specialties (ABMS), American Osteopathic Association, or other recognized board. Board certification is a voluntary process. To become board certified, a physician must: • Graduate from an accredited professional school • Complete a specific type and length of training in a specialty • Practice for a specified amount of time in that specialty • Pass an examination given by the professional specialty board For more information about your physician's board certification, visit the ABMS website at www.abms.org	Information is self-reported and updated every three (3) years during re-credentialing. Changes may occur between validation time frames.
Acceptance of New Patients	Indicates whether the provider is accepting new patients, accepting existing patients, accepting new and existing patients, accepting through referral only, accepting through a hospital or Facility, not accepting new patients.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Provider Language or Languages including American Sign Language	The languages other than English that the provider speaks and understands.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Clinical Staff Languages	The languages other than English that the clinical staff speaks and understands.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Telehealth Provider indicators (only Telehealth, no Telehealth, or both – Telehealth and in-person)	Provider indicator: only Telehealth, no Telehealth, or both – Telehealth and in-person	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

	Provider Definition	Information Collection and Validation
Telehealth site indicators (only Telehealth, no Telehealth, or both – Telehealth and in-person)	Site indicator: only Telehealth, no Telehealth, or both – Telehealth and in-person	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Facility Physical Accessibility Compliance	Refers to a site, Facility, work environment, service, or program that is easy to approach, enter, operate, participate in, and/or use safely and with dignity by a person with a disability.	Upon completion of a provider Facility site review, by using the data obtained through Attachment C of the FSR tool to determine and identify physical accessibility indicators.
Medical Group Affiliations	A group of contracted physicians that provides health care services to CalOptima Health Members.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Health Network Affiliations	A group of doctors and hospitals that provides health care services and has a contract with CalOptima Health.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
CalOptima Health Program (product)	The line of business the provider and/or Facility participates in.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Special Services	Services that the provider is certified in such as CCS.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Administrative Email Address	For office contact only.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Web URL Address	If applicable.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Public Email Addresses	Public email address (if applicable and attestation is completed) for patient communications.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Office Days and Hours	Days and times the provider and/or Facility is open for business.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Supervising Physician Full Name and License Number for Mid-level Practitioners	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

3. CalOptima Health 's Quality Improvement Department shall validate the Web-based Directory Hospital information every three (3) years. Validation shall consist of the following:

   a. Data sources; and

b. Limitations for each item of information on the Web-based Directory.

4. Web-based Directory Facility validation and frequency table:

	Facility Definition	**Information Collection and Validation**
Facility	General acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Facility Name	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Location	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Accreditation	Identifies whether the Facility undergoes a review to assess the quality of its systems and processes by an external accreditation organization.	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Hospital Quality Data from Recognized Sources	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.

IV. ATTACHMENT(S)

A. CalOptima Health Add/Change/Term (ACT) form
B. ACT Form User Guide
C. National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy Code Set

V. REFERENCE(S)

A. CalOptima Health Contract for Health Provider Care Services
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
F. CalOptima Health Policy DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment
~~F.~~G. CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process

~~G.~~H. CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services
~~H.~~I. CalOptima Health Policy GG.1608: Full Scope Site Reviews
~~I.~~J. CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
~~J.~~K. CalOptima Health Policy MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification
~~K.~~L. Health and Safety Code (HSC), §1367.27
~~L.~~M. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Supersedes APL 16-001)
~~M.~~N. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment (Supersedes APL 19-004~~)~~) (Revised August 24, 2022)
~~N.~~O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: ~~Inoperability~~Interoperability and Patient Access Final Rule
~~O.~~P. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031~~)~~) (Revised November 3, 2023)
~~P.~~Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (Supersedes APL 09-009)
~~Q.~~R. Medi-Cal Managed Care Division (MMCD) Policy Letter (PL) 00-002: Supersedes Policy Letter 97-09: Health Plan Provider Directory Policy, Guidelines, and Delivery Standards
~~R.~~S. Medi-Cal Managed Care Division (MMCD) Policy Letter (PL) 11-009: Update to Policy Letter 00-002: Update to Health Plan Provider Directory Policy and Guidelines
~~S.~~T. National Committee of Quality Assurance (NCQA) 2024 Health Plan (HP) Standards and Guidelines
~~T.~~U. NUCC Taxonomy Code List: https://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/pdf-mainmenu-53
~~U.~~V. Title 42, Code of Federal Regulations (CFR), § 438.10(h)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/17/2014	Department of Health Care Services (DHCS)	Approved As Submitted
01/26/2015	Department of Health Care Services (DHCS)	Approved As Submitted
07/06/2015	Department of Health Care Services (DHCS)	Approved As Submitted
07/26/2021	Department of Health Care Services (DHCS)	Approved As Submitted
05/02/2023	Department of Health Care Services (DHCS)	Approved As Submitted
07/03/2023	Department of Health Care Services (DHCS)	Approved As Submitted
06/13/2024	Department of Health Care Services (DHCS)	Approved As Submitted

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors
02/03/2022	Regular Meeting of the CalOptima Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1995	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	04/01/2004	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	07/01/2007	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2011	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	03/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	08/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2013	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2014	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	03/01/2015	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	03/15/2015	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	06/01/2015	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	07/01/2016	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	07/01/2017	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	03/07/2019	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	02/03/2022	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	01/01/2023	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	11/01/2023	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	05/01/2024	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	09/01/2024	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	12/05/2024	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Additions	Term referred to in the Addition, Change, and Termination (ACT) process to add a Provider, Practitioner or Facility to the system of record. Health Networks are recommended to submit ACT forms and necessary documentation as outlined in this policy to add a Provider, Practitioner or Facility pursuant to the terms of the Agreement.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Community Network	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Changes	Term referred to in the Addition, Change, and Termination (ACT) process to make a demographic or other change a Provider, Practitioner or Facility in the system of record. Health Networks are recommended to submit ACT forms and necessary documentation as outlined in this policy to make demographic or other changes to the system of record pursuant to the terms of the Agreement.
Delegated Provider Group	Health care entity with authority to credential its health care practitioners.
Doula	A birth worker who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, otherwise known as the perinatal period, for up to one year after pregnancy and provides support during miscarriage, stillbirth, and abortion (pregnancy termination) as set forth in DHCS APL 23-024: Doula Services.
Facility	For purposes of this policy, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a CalOptima Health program.
National Uniform Claim Committee (NUCC)	The official maintainer of the Health Care Provider Taxonomy code set. https://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/pdf-mainmenu-53
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Provider	For purposes of this Policy, any individual, entity, Health Network, or Delegated Provider Group that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.

Term	Definition
Telehealth	A method of delivering health care services by using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at a separate location from the Provider.
Terminations	Term referred to in the Addition, Change, and Termination (ACT) process to terminate a Provider, Practitioner or Facility from the system of record. Health Networks shall submit notification of termination pursuant to the terms of the Agreement.

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Policy:	EE.1101
Title:	**Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory**
Department:	Provider Network Operations
Section:	Provider Data Management Services
CEO Approval:	*/s/*
Effective Date:	11/01/1995
Revised Date:	12/05/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process for adding, changing, or terminating a Provider in the CalOptima Health Provider Directory and Web-based Directory.

II. POLICY

A. For each CalOptima Health program, CalOptima Health shall publish a printed hardcopy and online PDF version of the Provider Directory on a monthly basis, and a Web-based Directory that is updated within forty-eight (48) hours of an Addition, Change, or Termination of a Provider.

B. The Provider Directory shall include information on Health Networks, hospitals, Primary Care Providers (PCPs), OB/GYNs, specialists, behavioral health Providers, managed long-term services and support (MLTSS) Providers, urgent care centers, ancillary Providers, Facilities, and pharmacies who are credentialed and contracted with CalOptima Health directly or through a subcontracted agreement with a Health Network.

C. CalOptima Health shall ensure the printed hardcopy and online PDF version of the Provider Directory address Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) requirements for Provider Directories.

D. CalOptima Health shall submit the Medi-Cal Provider Directory to DHCS every six (6) months and shall include a PDF with the submission which DHCS can use for distribution, as needed.

1. CalOptima Health shall submit the Medi-Cal Provider Directory to DHCS on a monthly basis.

2. CalOptima Health shall address any findings during DHCS' Provider Directory reviews or medial audits within the timeframe specified by DHCS.

E. CalOptima Health shall update the Medi-Cal Provider Directory Application Programming Interface (API) in accordance with 42 CFR section 438.10(h)(3) and Health and Safety Code section 1367.27 and as outlined in Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule.

1. CalOptima Health and Health Networks shall conduct routine testing, monitoring, and system updates to ensure APIs function properly.

2. CalOptima Health and Health Networks shall attest to meeting all Provider Directory API requirements and shall submit attestation as outlined in Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule.

3. CalOptima Health and Health Networks shall reserve the right to deny or discontinue any third-party application's connections to an API if it is reasonably determined, consistent with the security risk analysis under the HIPAA Security Rule, that continued access presents an unacceptable risk to the security of PHI on CalOptima Health's systems.

   a. CalOptima Health's determination to deny or discontinue any third-party application's connection to an API shall be made using objective verifiable criteria that is applied fairly and consistently across all applications and developers.

4. CalOptima Health and Health Networks shall demonstrate to DHCS their ability to comply with interoperability requirements by submitting readiness, implementation and ongoing deliverables as directed by DHCS.

F. CalOptima Health and Health Networks shall report changes to information for a Provider or Facility in the CalOptima Health Provider Directory and Web-based Directory on an ongoing basis in accordance with this Policy.

G. CalOptima Health, Health Networks, Delegated Provider Groups, and Providers shall validate their directory information on a semi-annual basis in accordance with this Policy.

H. CalOptima Health shall require its contracted Providers be enrolled as Medi-Cal Providers, in accordance with DHCS APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment if there exists a state-level enrollment pathway.

I. CalOptima Health shall ensure the Web-based Provider Directory is made available in a machine-readable file and format, with search functionality in accordance with Title 42 of the Code of Federal Regulations, section 438.10(h)(4), and section 1367.27(c)(2) of the California Health and Safety Code.

III. PROCEDURE

A. CalOptima Health shall publish a Provider Directory for each CalOptima Health program and a Web-based Directory that includes, but is not limited to, the following information to help existing and prospective Members choose physicians:

1. Headers to indicate city or region names (in alphabetical order);

2. Name;

3. Gender;

4. Specialty;

5. Taxonomy (primary, secondary, tertiary) (See Attachment C: NUCC Taxonomy Code List);

6. Area of focus, if applicable;

7. National Provider Identifier (NPI);

8. Hospital affiliation(s);

9. Primary care clinic or Medical Group affiliations, if applicable;

10. Board certification, if applicable;

11. Age limits (Member age minimum, Member age maximum, gender restrictions);

12. Listing of languages spoken by the Provider, including American Sign Language;

13. Listing of languages spoken by clinical staff;

14. Telehealth Provider indicators:

    a. Only Telehealth;

    b. No Telehealth (only in-person); or

    c. Both Telehealth and in-person;

15. Telehealth site indicators:

    a. Only Telehealth;

    b. No Telehealth (only in-person); or

    c. Both Telehealth and in-person;

16. Practice address (including suite number);

17. City;

18. State;

19. Zip code;

20. Telephone number including area code;

21. Proximity to public transportation;

22. After-hours telephone number;

23. Office days and hours;

24. California license number and type of license;

25. Web site URL, if applicable;

26. Public email address, if available and attestation is obtained;

27. Administrative email address;

28. Facility physical accessibility compliance (OSHA);

29. Provider type;

30. CalOptima Health program(s) (Medi-Cal and/or Medicare);

31. Tier, if applicable;

32. Health Network affiliation;

33. Facility affiliations (hospital name);

34. Hospital admitting privileges;

35. An individual Provider's panel status is at least one (1) of the following:

    a. Accepting new Members;

    b. Accepting existing Members;

    c. Available by referral only;

    d. Available only through a hospital or Facility;

    e. Not accepting new patients; or

    f. Accepting new and existing patients;

36. Special services, panel status, or certification such as California Children's Services (CCS) and expiration; and

37. Supervising Physician full name and license number for mid-level Providers, when applicable.

B. CalOptima Health's Provider and Web-based Directories shall include:

1. All Providers who contract with a Health Network and CalOptima Health Community Network (CHCN) to deliver health care services to Members including, but not limited to:

    a. Physicians and surgeons;

    b. Indian Health Care Providers (IHCPs), nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, Doulas, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service Providers, nurse midwives, and dentists;

c. Federally Qualified Health Centers (FQHCs), Indian Health Facilities (IHF), Rural Health Clinics (RHCs), and primary care clinics to the extent they are available in CalOptima Health service area;

d. Health Home Program Providers;

e. Facilities, including but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities; and

f. Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.

2. Identification of Providers that are not available to all or new Members.

3. Instructions and information on how to use the Directory. The instructions shall describe and explain any acronyms and symbols used within the Provider Directory, information on how to use CalOptima Health services, and who to call for assistance.

   a. The Directory shall be available in threshold languages, in accordance with CalOptima Health Policies DD.2002: Cultural and Linguistic Services., and PA.1007: Delivery of PACE Services.

4. A statement informing Members that they are entitled to language interpreter services at no cost, including contact information on how to obtain language services.

5. Instructions on how to contact CalOptima Health if the Provider Directory information appears to be inaccurate.

6. Instructions on how to contact the Department of Health Care Services (DHCS) Medi-Cal Managed Care Office of the Ombudsman if the Provider Directory information appears to be inaccurate.

7. Instructions advising Members to contact Customer Service to verify the availability of selected Providers or to request additional information, such as Provider race/ethnicity data, physician education and training, and other relevant details as required by Member Experience (ME) 2, Element A, Factor 7 of the 2024 Health Plan (HP) Standards and Guidelines.

8. A disclosure statement assuring Members of full and equal access to Covered Services, regardless of disability status.

9. A listing of the physical accessibility indicators with the accessibility symbol listed before the word "Accessibility" pursuant to DHCS guidance and CalOptima Health Policy GG.1608: Full Scope Site Reviews.

C. Health Networks, CHCN, Delegated Provider Groups, or a Provider (as applicable) shall submit to the Provider Data Management Services (PDMS) Department a written request to add, change, or terminate a Provider from the CalOptima Health Provider Directory or Web-based Directory as follows:

1. Provider Additions: Minimum of thirty (30) calendar days advanced written notice;

2. Provider Changes: Minimum of thirty (30) calendar days advanced written notice; and

3. Provider Terminations: Minimum of ninety (90) calendar days advanced written notice in accordance with CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

D. On a semi-annual basis, a Health Network and CHCN will require contracted Providers to confirm that their information in the Provider Directory is accurate and/or update the information, if applicable.

E. CalOptima Health shall maintain a process and system by which Providers may submit verification or changes to their listed information in the Provider Directory in a manner consistent with guidance from the DHCS and applicable contractual obligations.

F. CalOptima shall maintain a process to continuously validate provider's Medi-Cal Enrollment status consistent with DHCS APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment if there is a state-level enrollment pathway.

G. Health Network, CHCN, Delegated Provider Group, or Provider Request to Add a Provider

1. CalOptima Health's PDMS Department shall add a Health Network, Delegated Provider Group and/or CHCN Provider to the system of record within five (5) business days of submission based on the effective date indicated on the CalOptima Health Add/Change/Term (ACT) form (Attachment A) or electronic notification (with applicable data) for inclusion in the Provider Directory and Web-based Directory. CalOptima Health requires its Health Networks, subdelegates, Delegated Provider Groups, Providers and practitioners to promptly inform CalOptima Health of any changes to information regarding Provider demographics, credentialing, panel status, and other information requested on the CalOptima Health ACT form (Attachment A) or electronic notification (with applicable data) to ensure data accuracy, integrity and to audit/confirm the information provided by its Providers is true and correct.

2. A Health Network, CHCN, Delegated Provider Group, or Provider add request shall include:

a. CalOptima Health (ACT) form (Attachment A) (recommended) or electronic notification with applicable data;

b. Signed W9 form;

c. Health Network contract front and signature page (if applicable);

d. Provider Profile: a complete Provider profile that includes the following information:

i. Legal, full name of the Provider, as shown on his or her medical license;

ii. Program information (contracted CalOptima Health programs) and effective date;

iii. Gender;

iv. Primary, secondary, and tertiary specialty, as applicable;

v. Board certified specialty, if applicable;

vi. Taxonomy (primary, secondary, tertiary) (See Attachment C: NUCC Taxonomy Code List);

vii. Area of focus, if applicable;

viii. Type 1 (individual) NPI and Type 2 (organizations) NPI, if applicable;

ix. State license number;

x. Address, phone and facsimile number for the Provider service location;

xi. Days and hours of operation;

xii. Hospital affiliation(s);

xiii. Accepting new patients;

xiv. Accepting existing Members;

xv. Available by referral only;

xvi. Available only through a hospital or Facility; or

xvii. Not accepting new patients;

xviii. Accepting new and existing patients

xix. Age limits (member age minimum, member age maximum, gender restrictions);

xx. Languages spoken by the physician including American Sign Language;

xxi. Languages spoken by clinical staff;

xxii. Telehealth Provider indicators:

a) Only Telehealth;

b) No Telehealth (only in-person); or

c) Both telehealth and in-person.

xxiii. Telehealth site indicators:

a) Only Telehealth;

b) No Telehealth (only in-person); or

c) Both telehealth and in-person;

xxiv. Medi-Cal enrolled (Y/N) and effective date;

xxv. Medicare enrolled (Y/N); and

xxvi. A copy of the "Provider Directory Listing Authorization" section of the physician profile for mid-level practitioners, when applicable.

e. For Facilities, a complete Facility profile that includes the following information:

i. Facility name;

ii. Location;

iii. Accreditation;

iv. Phone number;

v. NPI;

vi. Languages spoken at Facility; and

vii. Telehealth indicator, site location.

3. A Health Network, CHCN, Delegated Provider Group, or Provider shall submit a request to the PDMS Department by one (1) of the following methods:

a. E-mail to ProviderOnline@caloptima.org; or

b. Fax to 714-954-2330.

4. If discrepancies are identified, the PDMS department shall reject and return the request to the requesting Health Networks, CHCN, Delegated Provider Group, or Provider for clarification within five (5) business days. Once the discrepancies are resolved, the corrected information must be resubmitted to the PDMS Department within five (5) business days.

5. The PDMS Department shall update the Provider or Facility file(s) in the Provider information system and, subsequently, the Web-based Directory, within five (5) business days of receipt of completed information.

6. The PDMS department shall ensure provider NPIs are validated and added to the 274 Network Provider File, including but not limited to PCPs, Specialists, and Dyadic Care Services.

H. Health Network, CHCN, Delegated Provider Group, or Provider Request to Change demographic or other information for a Provider, Practitioner or Facility.

1. CalOptima Health's PDMS Department shall update demographic or other information in the system of record within five (5) business days of submission based on the effective date indicated on the CalOptima Health Add/Change/Term (ACT) form (Attachment A) or electronic notification (with applicable data) for inclusion in the Provider Directory and Web-based Directory. A Health Network, CHCN, Delegated Provider Group, or Provider change request shall include:

a. Legal, full name of the practitioner, as shown on his or her medical license;

b. Program information (contracted CalOptima Health programs) and effective date;

c. Primary, secondary, and tertiary specialty, as applicable;

d. Board certified specialty, if applicable;

e. Taxonomy (primary, secondary, tertiary) (See Attachment C: NUCC Taxonomy Code List);

f. Type 1 (individual) NPI and Type 2 (organizations) NPI, if applicable;

g. Tax identification number (TIN);

h. State license number;

i. Gender;

j. Address, telephone and facsimile number for the Provider service location, including a telephone number for after normal business hours, if applicable;

k. Days and hours of operation;

l. Hospital affiliation;

m. Accepting new patients;

n. Age limits (Member age minimum, Member age maximum, gender restrictions);

o. Languages spoken by the physician including American Sign Language;

p. Languages spoken by clinical staff;

q. Telehealth Provider indicators:

   i. Only Telehealth;

   ii. No Telehealth (only in-person); or

   iii. Both telehealth and in-person;

r. Telehealth site indicators:

   i. Only Telehealth;

   ii. No Telehealth (only in-person); or

   iii. Both telehealth and in-person;

s. Medi-Cal enrolled (Y/N) and effective date; and

t. Medicare enrolled (Y/N).

2. A Health Network, CHCN, Delegated Provider Group, or Provider shall submit requests for Provider changes to the PDMS Department by one (1) of the following methods:

   a. E-mail to: ProviderOnline@CalOptima.org; or

   b. Fax to: 714-954-2330.

3. If discrepancies are identified, the PDMS department shall return the profile to the requesting Health Networks, CHCN, Delegated Provider Group or Provider for clarification within five (5) business days. Once the discrepancies are resolved, the corrected information must be resubmitted to the PDMS Department within five (5) business days.

4. The PDMS Department shall update the Provider or Facility file(s) in the provider information system and the web-based directory within thirty (30) calendar days of receipt of completed information.

I. Health Network, CHCN, Delegated Provider Group, or Provider Request to Terminate a Provider or Facility:

1. CalOptima Health 's PDMS Department shall terminate a Provider or Facility in the system of record within five (5) business days of submission based on the termination date indicated on the CalOptima Health ACT form (Attachment A) or electronic notification (with applicable data) for inclusion in the Provider Directory and Web-based Directory. A Health Network, CHCN, Delegated Provider Group, or Provider termination request shall include:

   a. A copy of the Provider or Facility termination notice with the effective date for termination.

   b. For a PCP who terminates from CHCN and requests to maintain the relationship with the Member:

      i. The Provider shall submit a written request to CalOptima Health's Provider Relations Department at least sixty (60) calendar days prior to the expected date of termination including the Health Network name for Member assignment as appropriate.

      ii. The PCP must have an active affiliation and their panel status "open" with the selected Health Network the Members are being assigned to.

2. For terminating Providers, CalOptima Health or the Health Network shall notify affected Members and DHCS, as applicable, in accordance with CalOptima Health Policies DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment, DD.2008: Health Network Selection Process, DD.2012: Member Notification of Change in the Availability or Location of Covered Services, MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification, and GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services. The PDMS Department shall notify Customer Service of Provider termination for purpose of Member notification and re-assignment of Members.

J. On a weekly basis, the PDMS Department shall send to the Health Networks and CHCN Provider, Practitioner and Facility reports of Additions, Changes, and Terminations for review of accuracy.

1. If discrepancies are identified on any Provider files, Health Networks and CHCN shall address the discrepancies.

a. Upon addressing discrepancies, the Health Network or CHCN shall notify the PDMS Department.

b. The PDMS Department shall update the Provider, practitioner and Facility files within five (5) business days in the provider information system and shall update the Web-based Directory.

K. On a monthly basis, CalOptima Health shall obtain an electronic update from the National Committee on Quality Assurance (NCQA) regarding providers who achieve Patient-Centered Medical Home (PCMH) recognition status. The updates from NCQA shall be seen on the Web-based Directory within ten (10) calendar days after receipt of the data file from NCQA.

L. Verification of Provider Information

1. CalOptima Health and Health Networks shall verify and update all information outlined in Section III.A. of this Policy to ensure accuracy of the information listed in the Provider Directory and Web-based Directory. CalOptima Health and Health Networks shall notify contracted Providers of the requirement to maintain and attest to the accuracy of Provider Directory information.

a. Notification

i. On a semi-annual basis, CalOptima Health shall notify and instruct Providers of the process to verify or update information listed in the Provider Directory and Web-based Directory, in a manner consistent with guidance from DHCS and applicable contractual obligations.

b. Verification

i. On a semi-annual basis, CalOptima Health shall distribute a Provider Data Universe to Health Networks and CHCN in the first (1st) and third (3rd) quarter of each calendar year.

ii. Health Networks and CHCN shall conduct validation of all information listed in the Provider Data Universe in accordance with this Policy.

iii. Health Networks and CHCN shall document the outcome of each attempt to verify Provider information.

iv. If through this process, a Health Network or CHCN discovers a Provider has retired, ceased practicing, or if the Provider is no longer affiliated with a practice, CalOptima Health shall remove the Provider from the Provider Directory in accordance with Section III.H. of this Policy.

c. Provider Directory Validation Attestation

i. Health Networks and CHCN shall require contracted Providers to validate and attest in writing to the accuracy of their Provider Directory information.

ii. If a Provider fails to respond to the request for validation and written attestation within thirty (30) business days, Health Networks and CHCN shall attempt to verify if the Provider information is accurate or requires updating within fifteen (15) business days.

iii. If a Health Network or CHCN is unable to verify whether the Provider's information is accurate or requires updating, a notice shall be sent to the Provider informing them of the intent to remove them from the Provider Directory for failure to submit appropriate validation and written attestation in accordance with this Policy.

a) Health Networks and CHCN shall notify Providers ten (10) business days prior to removal from the Provider Directory.

i) Providers that fail to respond will be removed from the Provider Directory in accordance with Section III.H. of this Policy.

ii) Providers will not be removed from the Provider Directory if a response is received before the end of the tenth (10th) business day.

iv. A Provider's failure to validate and attest to the accuracy of their Provider Directory data may result in panel closure, suppression from the Provider Directory, and/or delay of payment.

v. General acute care hospitals shall not be required to provide a response.

d. Collection and Submission of Provider Attestation

i. Health Networks and CHCN shall collect written Provider attestations from all contracted Providers for annual submission to the CalOptima Health Audit and Oversight Department.

ii. Health Networks and CHCN shall submit written Provider attestations, as requested by CalOptima Health 's Audit and Oversight department, in the fourth (4th) quarter of each calendar year.

iii. Written Provider attestations must be stored electronically for a minimum of ten (10) years.

M. Access to CalOptima Health Provider Directory and Web-based Directory

1. CalOptima Health shall provide Members, prospective Members, Providers and members of the public information from the CalOptima Health Provider Directory and Web-based Directory in alternate media formats. Alternate media formats include:

a. Print

i. CalOptima Health staff shall send by U.S. Postal Service mail to new Members the CalOptima Health Provider Directory upon enrollment in the CalOptima Health program or by request, postmarked no later than five (5) business days following the date of the request and in accordance with CalOptima Health Policy DD.2008: Health Network Selection Process; or

b. Telephone

i. CalOptima Health staff shall utilize the Web-based Directory to assist Members over the phone in finding a Provider. If a Member requests Provider information or the CalOptima Health Provider Directory, CalOptima Health staff shall print and send the requested information to the Member by U.S. mail.

N. CalOptima Health shall review its Web-based Directory for usability every three (3) years. Review shall include, but is not limited to:

1. Font size;

2. Reading level;

3. Ease of navigation;

4. Intuitive content organization; and

5. Directories in different languages.

O. Validation of Web-based Directory

1. A Health Network and CHCN shall validate the Web-based Directory Provider, Practitioner and Facility information at least annually. Validation shall consist of the following:

a. Data sources, and

b. Limitations for each item of information on the Web-based Directory.

2. Web-based Directory Provider, Practitioner and Facility validation and frequency table:

	Provider Definition	**Information Collection and Validation**
Name	The alternative name preferred by and as specified by the practitioner, provider, or Facility which may be familiar to patients and can be published on provider directory.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Provider Type	Includes: Physicians and surgeons; Nurse practitioners, physician assistants, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists, professional clinical counselors, qualified autism service providers, nurse midwives, and dentists;	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

	Provider Definition	Information Collection and Validation
	Federally Qualified Health Centers (FQHCs) or primary care clinics; Facilities, including but not limited to, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities; and Pharmacies, clinical laboratories, imaging centers, and other facilities providing contracted health care services.	
License Number	California license number of the practitioner. Catenate the license type letter (NP, CNM, and PA for mid-level; A, C, G, and 20A for MD and DO; E for DPM) and license number together and no space in between.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
NPI	National provider identifier of the practitioner (NPI type 1, 10 digits) National provider identifier of the hospital (NPI type 2, 10 digits)	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Gender	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice Address	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice City	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice State	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Practice Zip Code	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Phone Number	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between the validation time frames.

	Provider Definition	Information Collection and Validation
After Hours Phone Number	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Age Limits	Member age minimum, member age maximum and gender restriction.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Specialty	The clinical area in which the CalOptima Health contracted physician received specialized training, such as a residency or fellowship.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Taxonomy (primary, secondary, tertiary)	The taxonomy code of the specialty for which the practitioner has.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Area of Focus	The specific focus of the specialty for which the practitioner has.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Facility Hospital Affiliations (Hospital Name)	The name of CalOptima Health contracted hospital where the practitioner him/herself is on staff and/or having admitting privilege.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames
Hospital Admitting Privileges	Includes: Active, Provisional, Courtesy, Surgical, Consultant, Suspended, Limited, Associate Staff, Honorary Staff, and Senior Attending.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

	Provider Definition	Information Collection and Validation
Board Certification	When a health care practitioner is board certified, it means that he or she has applied for and been awarded certification from the American Board of Medical Specialties (ABMS), American Osteopathic Association, or other recognized board. Board certification is a voluntary process. To become board certified, a physician must: • Graduate from an accredited professional school • Complete a specific type and length of training in a specialty • Practice for a specified amount of time in that specialty • Pass an examination given by the professional specialty board For more information about your physician's board certification, visit the ABMS website at www.abms.org	Information is self-reported and updated every three (3) years during re-credentialing. Changes may occur between validation time frames.
Acceptance of New Patients	Indicates whether the provider is accepting new patients, accepting existing patients, accepting new and existing patients, accepting through referral only, accepting through a hospital or Facility, not accepting new patients.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Provider Language or Languages including American Sign Language	The languages other than English that the provider speaks and understands.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Clinical Staff Languages	The languages other than English that the clinical staff speaks and understands.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Telehealth Provider indicators (only Telehealth, no Telehealth, or both – Telehealth and in-person)	Provider indicator: only Telehealth, no Telehealth, or both – Telehealth and in-person	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

	Provider Definition	Information Collection and Validation
Telehealth site indicators (only Telehealth, no Telehealth, or both – Telehealth and in-person)	Site indicator: only Telehealth, no Telehealth, or both – Telehealth and in-person	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Facility Physical Accessibility Compliance	Refers to a site, Facility, work environment, service, or program that is easy to approach, enter, operate, participate in, and/or use safely and with dignity by a person with a disability.	Upon completion of a provider Facility site review, by using the data obtained through Attachment C of the FSR tool to determine and identify physical accessibility indicators.
Medical Group Affiliations	A group of contracted physicians that provides health care services to CalOptima Health Members.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Health Network Affiliations	A group of doctors and hospitals that provides health care services and has a contract with CalOptima Health.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
CalOptima Health Program (product)	The line of business the provider and/or Facility participates in.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Special Services	Services that the provider is certified in such as CCS.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Administrative Email Address	For office contact only.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Web URL Address	If applicable.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Public Email Addresses	Public email address (if applicable and attestation is completed) for patient communications.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Office Days and Hours	Days and times the provider and/or Facility is open for business.	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.
Supervising Physician Full Name and License Number for Mid-level Practitioners	N/A	Information is self-reported and updated at least annually by the provider. Changes may occur between validation time frames.

3. CalOptima Health 's Quality Improvement Department shall validate the Web-based Directory Hospital information every three (3) years. Validation shall consist of the following:

   a. Data sources; and

b. Limitations for each item of information on the Web-based Directory.

4. Web-based Directory Facility validation and frequency table:

	Facility Definition	**Information Collection and Validation**
Facility	General acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Facility Name	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Location	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Accreditation	Identifies whether the Facility undergoes a review to assess the quality of its systems and processes by an external accreditation organization.	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.
Hospital Quality Data from Recognized Sources	N/A	Information is self-reported and updated every three years during re-credentialing. Changes may occur between validation time frames.

IV. ATTACHMENT(S)

A. CalOptima Health Add/Change/Term (ACT) form
B. ACT Form User Guide
C. National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy Code Set

V. REFERENCE(S)

A. CalOptima Health Contract for Health Provider Care Services
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
F. CalOptima Health Policy DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment
G. CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process

H. CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services
I. CalOptima Health Policy GG.1608: Full Scope Site Reviews
J. CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
K. CalOptima Health Policy MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification
L. Health and Safety Code (HSC), §1367.27
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Supersedes APL 16-001)
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment (Supersedes APL 19-004) (Revised August 24, 2022)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031) (Revised November 3, 2023)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (Supersedes APL 09-009)
R. Medi-Cal Managed Care Division (MMCD) Policy Letter (PL) 00-002: Supersedes Policy Letter 97-09: Health Plan Provider Directory Policy, Guidelines, and Delivery Standards
S. Medi-Cal Managed Care Division (MMCD) Policy Letter (PL) 11-009: Update to Policy Letter 00-002: Update to Health Plan Provider Directory Policy and Guidelines
T. National Committee of Quality Assurance (NCQA) 2024 Health Plan (HP) Standards and Guidelines
U. NUCC Taxonomy Code List: https://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/pdf-mainmenu-53
V. Title 42, Code of Federal Regulations (CFR), § 438.10(h)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/17/2014	Department of Health Care Services (DHCS)	Approved As Submitted
01/26/2015	Department of Health Care Services (DHCS)	Approved As Submitted
07/06/2015	Department of Health Care Services (DHCS)	Approved As Submitted
07/26/2021	Department of Health Care Services (DHCS)	Approved As Submitted
05/02/2023	Department of Health Care Services (DHCS)	Approved As Submitted
07/03/2023	Department of Health Care Services (DHCS)	Approved As Submitted
06/13/2024	Department of Health Care Services (DHCS)	Approved As Submitted

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors
02/03/2022	Regular Meeting of the CalOptima Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1995	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	04/01/2004	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	07/01/2007	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2011	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	03/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	08/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2013	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2014	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	03/01/2015	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	03/15/2015	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	06/01/2015	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	07/01/2016	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	07/01/2017	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	03/07/2019	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	02/03/2022	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	01/01/2023	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	11/01/2023	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	05/01/2024	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	09/01/2024	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	12/05/2024	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Additions	Term referred to in the Addition, Change, and Termination (ACT) process to add a Provider, Practitioner or Facility to the system of record. Health Networks are recommended to submit ACT forms and necessary documentation as outlined in this policy to add a Provider, Practitioner or Facility pursuant to the terms of the Agreement.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Community Network	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Changes	Term referred to in the Addition, Change, and Termination (ACT) process to make a demographic or other change a Provider, Practitioner or Facility in the system of record. Health Networks are recommended to submit ACT forms and necessary documentation as outlined in this policy to make demographic or other changes to the system of record pursuant to the terms of the Agreement.
Delegated Provider Group	Health care entity with authority to credential its health care practitioners.
Doula	A birth worker who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, otherwise known as the perinatal period, for up to one year after pregnancy and provides support during miscarriage, stillbirth, and abortion (pregnancy termination) as set forth in DHCS APL 23-024: Doula Services.
Facility	For purposes of this policy, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a CalOptima Health program.
National Uniform Claim Committee (NUCC)	The official maintainer of the Health Care Provider Taxonomy code set. https://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/pdf-mainmenu-53
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Provider	For purposes of this Policy, any individual, entity, Health Network, or Delegated Provider Group that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.

Term	Definition
Telehealth	A method of delivering health care services by using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at a separate location from the Provider.
Terminations	Term referred to in the Addition, Change, and Termination (ACT) process to terminate a Provider, Practitioner or Facility from the system of record. Health Networks shall submit notification of termination pursuant to the terms of the Agreement.

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Add, Change and Termination Form

It is recommended that this form be used to report any additions, changes and/or terminations to a provider's network affiliates.
If this form is being used, a separate form must be completed for each contracted provider being terminated or whose status is changing.

Health Network Name:

Program (Check all that apply): ☐ **Medi-Cal** ☐ **OneCare** ☐ **PACE**

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)	(Middle Initial)	
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME	PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE / ZIP
REMIT ADDRESS		CITY	STATE / ZIP
OFFICE MANAGER	PHONE	FAX	PUBLIC EMAIL ADDRESS
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CPSP	

HOSPITAL/FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES		
1. _____	2. _____	3. _____
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF
☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT
☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL
☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL
☐ SUSPENDED	☐ SUSPENDED	☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ NEW ADD OR AFFILIATION

REQUIREMENTS: The Provider Relations (PR) representative must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by Provider Data Management Services (PDMS) and returned to the PR representative.

Effective Date **(required)**:	Date Credentialing Completed (within the last three years)	Current Facility Site Review Date (within the last three years)
PROVIDER TYPE	☐ **ANCILLARY/ALLIED HEALTH** ☐ **PCP** ☐ **SPECIALIST** ☐ **ECM** ☐ **COMMUNITY SUPPORTS**	☐ **Open Panel** ☐ **Closed Panel** ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ CHANGE IN PANEL STATUS

REQUIREMENTS: Panel changes are effective the date of processing.

PROVIDER TYPE (If applicable, check both)		
	☐ **PCP** ☐ **SPECIALIST** ☐ **ECM** ☐ **COMMUNITY SUPPORTS**	☐ **Open Panel** ☐ **Closed Panel** ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ TAX ID CHANGE

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax ID (required):	Previous Tax ID	New Tax ID

ACTION REQUIREMENTS (cont.) (Check all that apply)

☐ TERMINATION

REQUIREMENTS: Complete this form for each provider being terminated from its provider network affiliates. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by PDMS and returned to the PR representative.

Effective date (required):	☐ **PCP** ☐ **SPECIALIST** ☐ **ANCILLARY**

Date CalOptima Health received the termination notice:

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider retired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider deceased
- ☐ Provider unwilling to accept member/payment terms
- ☐ Termed due to review action

PCP Termination: Assign member to new PCP: _____
Name of new PCP

Number of members impacted (as of date received): ☐ **Medi-Cal** _____ ☐ **OneCare** _____

Date member notice was mailed (if member notice has not been sent, please put anticipated date and notify CalOptima Health if date changes):

Number of days' notice provider gave to MCP:

☐ ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a facility site review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-Person	
Address		City	State / ZIP
Phone	Fax	Office Hours	After Hours Phone
Office Manager		Email Address	

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person	
Address		City	State / Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number
Office Manager		Email Address	

☐ LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages spoken by provider, if fluent with communicating about medical care, put an asterisk next to the language (^ Language fluency is optional to disclose and not required)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Language services, such as American Sign Language (ASL), and interpreter services
Check all that apply

- ☐ In-office ASL interpreter
- ☐ In-office medical interpreter
- ☐ Other type of in-office interpreter service, fill in here _____

☐ Race/Ethnicity

^ Race/ethnicity of Provider. Check all that apply:

- ☐ American Indian Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Choose not to share

☐ OTHER

Comments:

PROVIDER RELATIONS REPRESENTATIVE
(Please print)

PROVIDER NAME
(Please print)

SIGNATURE	DATE

^Optional to answer and not required

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CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

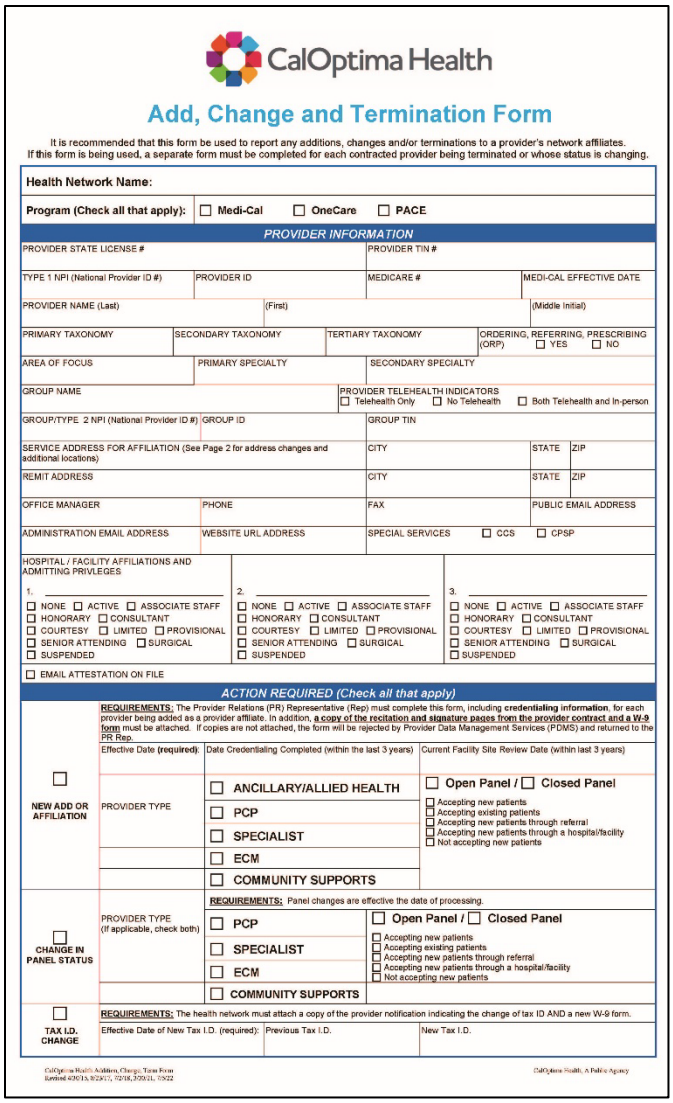
REQUIREMENTS

CalOptima Health requires its health networks (HN), subdelegates, providers and practitioners to promptly inform us of any changes to information regarding practitioner:

- **Demographics**
- **Credentialing**
- **Panel status —** including accepting new patients, accepting existing patients, accepting through a referral, accepting through a facility or hospital, and not accepting new patients
- **Other information requested in this file**

HEALTH NETWORKS

All HNs and subdelegates shall promptly, but no later than five business days from a change in the practitioner's panel status, inform CalOptima Health of such change. The HN, on a quarterly basis, verifies and updates the practitioner's information. The HN verification process includes a methodology to audit and confirm that the information provided by its practitioners is true and correct. HN maintains records of such verifications and shall provide them during the second and fourth quarters of the year.



CalOptima Health

Add, Change and Termination Form

It is recommended that this form be used to report any additions, changes and/or terminations to a provider's network affiliates.
If this form is being used, a separate form must be completed for each contracted provider being terminated or whose status is changing.

Health Network Name:

Program (Check all that apply): ☐ Medi-Cal ☐ OneCare ☐ PACE

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)		(Middle Initial)
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME		PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person	
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE ZIP
REMIT ADDRESS		CITY	STATE ZIP
OFFICE MANAGER	PHONE	FAX	PUBLIC EMAIL ADDRESS
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CPSP	

HOSPITAL / FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES

1.	2.	3.
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ **NEW ADD OR AFFILIATION**

REQUIREMENTS: The Provider Relations (PR) Representative (Rep) must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by Provider Data Management Services (PDMS) and returned to the PR Rep.

Effective Date (required):	Date Credentialing Completed (within the last 3 years)	Current Facility Site Review Date (within last 3 years)
PROVIDER TYPE	☐ ANCILLARY/ALLIED HEALTH ☐ PCP ☐ SPECIALIST ☐ ECM ☐ COMMUNITY SUPPORTS	☐ Open Panel / ☐ Closed Panel ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ **CHANGE IN PANEL STATUS**

REQUIREMENTS: Panel changes are effective the date of processing.

PROVIDER TYPE (If applicable, check both)	
☐ PCP ☐ SPECIALIST ☐ ECM ☐ COMMUNITY SUPPORTS	☐ Open Panel / ☐ Closed Panel ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ **TAX I.D. CHANGE**

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax I.D. (required):	Previous Tax I.D.	New Tax I.D.

CalOptima Health Addition, Change, Term Form
Revised 4/30/15, 8/24/17, 02/16, 3/20/21, 05/22

CalOptima Health, A Public Agency

ACT FORM INSTRUCTIONS

Please read through these instructions carefully, which specify the exact data content and data format of each column on the roster.

1) Do not change column name, column order, data format and do not add in new columns.
2) Any column left "blank" or null shall be rejected by the health plan.
3) Submit any practitioner (i.e. PCP, specialist, mid-level) participating within your CalOptima Health network.
4) Submit any practice location (medical office, clinic, etc.) participating within you CalOptima Health network.
5) Submit any hospital that provides health care services to CalOptima Health members within your network, regardless of CalOptima Health contractual relationship.
6) Submit any ancillary facility and its affiliated practitioners that provides health care services to CalOptima Health members within your network, regardless of CalOptima Health contractual relationship.
7) All provider types (taxonomy and specialty):
   a. Must be credentialed
   b. Only the taxonomy and specialty that are contracted at the location
   c. Please refer to the taxonomy codes submitted on the sFTP for taxonomy code table
8) Practice locations must pass Facility Site Review (FSR) - Physician and mid-level.
9) ACT Form submissions that deviate from the criteria listed above will be REJECTED and returned.
10) E-mail completed ACT form and required support documents to ProviderOnline@caloptima.org.

CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

HOW TO SUBMIT CALOPTIMA HEALTH ACT FORM

1) Complete all relevant sections of the CalOptima Health ACT Form
2) Attach a competed and signed W9
3) Include a copy of the front of your HN contract and signature page or CCN/COD Contract Summary
4) Complete a provider profile that includes the information listed below
5) E-mail completed ACT form and required support documents to ProviderOnline@caloptima.org
6) For questions and more information, call the CalOptima Health Provider Relations department at **714-246-8600**

Scope of Provider Type

1) **Physician** (individual)
   - Medical Doctor (M.D.)
   - Doctor of Osteopathic Medicine (D.O.)
   - Doctor of Podiatric Medicine (D.P.M.)

(2) **Mid-level** (individual)
   - Certified Nurse Practitioners (CNP)
   - Certified Nurse Midwifes (CNM)
   - Physician Assistants (PA)

(3) **Hospital**: Any hospital within the HN network, regardless of CalOptima Health's contractual relationship. Samples include, but are not limited to the following:

- Ambulatory surgery center
- Hospital with acute care
- Psychiatry hospital

(4) **Ancillary**: Any facility that provides health care services to CalOptima Health members within the HN, regardless of CalOptima Health-contractual relationship. Examples include but are not limited to the following:

- Adult day health care center/community base adult service
- Audiology
- Durable Medical Equipment
- End-stage renal disease provider/dialysis unit/hemodialysis
- Home health
- Home infusion
- Hospice
- Clinical laboratory
- Long-term services and supports
- Occupational therapy
- Physical therapy
- Portable X-ray supplier
- Radiology center
- Rehabilitation center
- Skilled nursing facility
- Transportation services
- Urgent care

… and others

Practitioner Practices at Ancillary (individual) – examples include are but not limited to the following:

- Acupuncturist
- Audiologist
- Chiropractor
- Physical therapist
- Radiation therapist
- Occupational therapist
- Speech therapist

… and others

CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

WHEN SHOULD I SUBMIT AN ACT REQUEST?

Additions: Term referred to in the ACT process to add a provider, practitioner or facility to CalOptima Health's system. HNs and subdelegates shall submit ACT forms and required documentation as outlined in this policy when adding a provider, practitioner or facility pursuant to the terms of the agreement. To add an additional location to an existing provider, please check the additional location box on Page 2 of the ACT form.

Changes: Term referred to in the ACT process to make a demographic or other change to a provider, practitioner or facility in CalOptima Health's system. HNs and subdelegates shall submit ACT forms and required documentation as outlined in this policy when making demographic or other changes to the CalOptima Health system pursuant to the terms of the agreement.

Terminations: Term referred to in the ACT process when terminating a provider, practitioner or facility from CalOptima Health's system. HNs and subdelegates shall submit notification of terminations pursuant to the terms of the agreement.

ADDITIONAL SUBMISSION REQUIREMENTS

Additions: When making an addition request, the group name, National Provider Identifier (NPI) and Tax Identification Number (TIN) must all correspond. In the event your submission consists of non-corresponding identifiers, it will not be honored.

Terminations: When requesting a termination of a provider's TIN, you must submit the group NPI along with the TIN.

Health Networks and Subdelegates

- Health networks and providers must take the following steps when requesting to move a provider from one group NPI to another group NPI:
    1. Submit ACT Termination form to remove the provider from the CalOptima Health system
    2. Submit ACT Addition form and required documentation as outlined in EE.1101 to add the provider to the CalOptima Health system with the new group NPI

    Note: Each of the above steps must be done separately.
- If you are adding or changing the address of a primary care provider (PCP), you must include the date of request along with a Facility Site Review (FSR) completion form with your submission request.

E-mail completed ACT form and required support documents to ProviderOnline@caloptima.org

Disclaimer – CalOptima Health will limit the registration of office locations outside of Orange County to only those that are addressing network adequacy and member access gaps unless indicated otherwise within the contract.

CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

Sample Addition

CalOptima Health

Add, Change and Termination Form

It is recommended that this form be used to report any additions, changes and/or terminations to a provider's network affiliates.
If this form is being used, a separate form must be completed for each contracted provider being terminated or whose status is changing.

Health Network Name:

Program (Check all that apply): ☐ Medi-Cal ☐ OneCare ☐ PACE

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)		(Middle Initial)
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME	PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
GROUP TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)	CITY	STATE	ZIP
REMIT ADDRESS	CITY	STATE	ZIP
OFFICE MANAGER	PHONE	FAX	PUBLIC EMAIL ADDRESS
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CPSP	

HOSPITAL/FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES

1. _____	2. _____	3. _____
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF
☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT
☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL
☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL
☐ SUSPENDED	☐ SUSPENDED	☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ **NEW ADD OR AFFILIATION**

REQUIREMENTS: The Provider Relations (PR) representative must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by Provider Data Management Services (PDMS) and returned to the PR representative.

Effective Date (required)	Date Credentialing Completed (within the last three years)	Current Facility Site Review Date (within the last three years)

PROVIDER TYPE

- ☐ ANCILLARY/ALLIED HEALTH
- ☐ PCP
- ☐ SPECIALIST
- ☐ ECM
- ☐ COMMUNITY SUPPORTS

☐ Open Panel ☐ Closed Panel

- ☐ Accepting new patients
- ☐ Accepting existing patients
- ☐ Accepting new patients through referral
- ☐ Accepting new patients through a hospital/facility
- ☐ Not accepting new patients

☐ **CHANGE IN PANEL STATUS**

REQUIREMENTS: Panel changes are effective the date of processing.

PROVIDER TYPE (If applicable, check both)

- ☐ PCP
- ☐ SPECIALIST
- ☐ ECM
- ☐ COMMUNITY SUPPORTS

☐ Open Panel ☐ Closed Panel

- ☐ Accepting new patients
- ☐ Accepting existing patients
- ☐ Accepting new patients through referral
- ☐ Accepting new patients through a hospital/facility
- ☐ Not accepting new patients

☐ **TAX ID CHANGE**

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax ID (required)	Previous Tax ID	New Tax ID

CalOptima Health Addition, Change, Term Form
Revised 03/18, 8/18AT, 10/18, 05/20, 7/20, 9/21

CalOptima Health, A Public Agency

^Optional to answer and not required

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CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

ACTION REQUIREMENTS (cont.) (Check all that apply)

☐ TERMINATION

REQUIREMENTS: Complete this form for each provider being terminated from its provider network affiliation. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by PDMS and returned to the PR representative.

Effective date (required): ☐ PCP ☐ SPECIALIST ☐ ANCILLARY

Date CalOptima Health received the termination notice:

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider retired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider deceased
- ☐ Provider unwilling to accept member/payment terms
- ☐ Termed due to review action

PCP Termination: Assign member to new PCP: _____
Name of new PCP

Number of members impacted (as of date received): ☐ **Medi-Cal** _____ ☐ **OneCare** _____

Date member notice was mailed (if member notice has not been sent, please put anticipated date and notify CalOptima Health if date changes):

Number of days' notice provider gave to MCP:

☐ ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a facility site review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS Check one: [ ] ADD [ ] TERM	Effective Date (required):	SITE TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-Person	
Address:		City	State / ZIP
Phone	Fax	Office Hours	After Hours Phone
Office Manager		Email Address	

SERVICE ADDRESS Check one: [ ] ADD [ ] TERM	Effective Date (required):	SITE TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person	
Address:		City	State / Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number
Office Manager		Email Address	

☐ LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages spoken by Provider, if fluent with communicating about medical care, put an asterisk next to the language (* Language fluency is optional to disclose and not required)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Language services, such as American Sign Language (ASL), and interpreter services
Check all that apply:

- ☐ In-office ASL interpreter
- ☐ In-office medical interpreter
- ☐ Other type of in-office interpreter service, fill in here _____

☐ Race/Ethnicity

^ Race/ethnicity of provider. Check all that apply:

- ☐ American Indian Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Choose not to share

☐ OTHER

Comments:

PROVIDER RELATIONS REPRESENTATIVE
(Please print)

PROVIDER NAME
(Please print)

SIGNATURE	DATE

^Optional to answer and not required

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CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

Sample Change

CalOptima Health

Add, Change and Termination Form

It is recommended that this form be used to report any additions, changes and/or terminations to a provider's network affiliates.
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Health Network Name:

Program (Check all that apply): ☐ Medi-Cal ☐ OneCare ☐ PACE

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)		(Middle Initial)
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME	PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE ZIP
REMIT ADDRESS		CITY	STATE ZIP
OFFICE MANAGER	PHONE	FAX	PUBLIC EMAIL ADDRESS
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ DDS ☐ CPSP	

HOSPITAL/FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES

1. _____	2. _____	3. _____
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF
☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT
☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL
☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL
☐ SUSPENDED	☐ SUSPENDED	☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ NEW ADD OR AFFILIATION

REQUIREMENTS: The Provider Relations (PR) representative must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by Provider Data Management Services (PDMS) and returned to the PR representative.

Effective Date (required):	Date Credentialing Completed (within the last three years)	Current Facility Site Review Date (within the last three years)
PROVIDER TYPE	☐ ANCILLARY/ALLIED HEALTH ☐ PCP ☐ SPECIALIST ☐ ECM ☐ COMMUNITY SUPPORTS	☐ Open Panel ☐ Closed Panel ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ CHANGE IN PANEL STATUS

REQUIREMENTS: Panel changes are effective the date of processing.

PROVIDER TYPE (If applicable, check both)		
	☐ PCP ☐ SPECIALIST ☐ ECM ☐ COMMUNITY SUPPORTS	☐ Open Panel ☐ Closed Panel ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ TAX ID CHANGE

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax ID (required):	Previous Tax ID	New Tax ID

CalOptima Health Addition, Change, Term Form
Revised 03/18, 8/2017, 10/18, 1/2020, 7/2020, 9/2021

CalOptima Health, A Public Agency

^Optional to answer and not required

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CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

ACTION REQUIREMENTS (cont.) (Check all that apply)

☐ TERMINATION

REQUIREMENTS: Complete this form for each provider being terminated from its provider network affiliations. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by POMS and returned to the PR representative.

Effective date (required):	☐ PCP ☐ SPECIALIST ☐ ANCILLARY
Date CalOptima Health received the termination notice:	

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider retired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider deceased
- ☐ Provider unwilling to accept member/payment terms
- ☐ Termed due to review action

PCP Termination: Assign member to new PCP: _____
Name of new PCP

Number of members impacted (as of date received): ☐ **Medi-Cal** _____ ☐ **OneCare** _____

Date member notice was mailed (if member notice has not been sent, please put anticipated date and notify CalOptima Health if date changes):

Number of days' notice provider gave to MCP:

☐ ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a facility site review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS Check one: [ ] ADD [ ] TERM	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-Person		
Address:		City	State	ZIP
Phone	Fax	Office Hours	After Hours Phone	
Office Manager		Email Address		

SERVICE ADDRESS Check one: [ ] ADD [ ] TERM	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
Address:		City	State	Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number	
Office Manager		Email Address		

☐ LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages spoken by Provider, if fluent with communicating about medical care, put an asterisk next to the language (* Language fluency is optional to disclose and not required)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Language services, such as American Sign Language (ASL), and interpreter services
Check all that apply

- ☐ In-office ASL interpreter
- ☐ In-office medical interpreter
- ☐ Other type of in-office interpreter service, fill in here _____

☐ Race/Ethnicity

^ Race/ethnicity of provider. Check all that apply:

- ☐ American Indian Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Choose not to share

☐ OTHER

Comments:

PROVIDER RELATIONS REPRESENTATIVE
(Please print)

PROVIDER NAME
(Please print)

SIGNATURE	DATE

^Optional to answer, but encouraged

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CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

Sample Termination

CalOptima Health

Add, Change and Termination Form

It is recommended that this form be used to report any additions, changes and/or terminations to a provider's network affiliates.
If this form is being used, a separate form must be completed for each contracted provider being terminated or whose status is changing.

Health Network Name:

Program (Check all that apply): ☐ Medi-Cal ☐ OneCare ☐ PACE

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)		(Middle Initial)
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME	PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE ZIP
REMIT ADDRESS		CITY	STATE ZIP
OFFICE MANAGER	PHONE	FAX	PUBLIC EMAIL ADDRESS
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CPSP	

HOSPITAL/FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES

1.	2.	3.
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ **NEW ADD OR AFFILIATION**

REQUIREMENTS: The Provider Relations (PR) representative must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, a copy of the recitation and signature pages from the provider contract and a W-9 form must be attached. If copies are not attached, the form will be rejected by Provider Data Management Services (PDMS) and returned to the PR representative.

Effective Date (required):	Date Credentialing Completed (within the last three years)	Current Facility Site Review Date (within the last three years)

PROVIDER TYPE

- ☐ ANCILLARY/ALLIED HEALTH
- ☐ PCP
- ☐ SPECIALIST
- ☐ ECM
- ☐ COMMUNITY SUPPORTS

☐ Open Panel ☐ Closed Panel

- ☐ Accepting new patients
- ☐ Accepting existing patients
- ☐ Accepting new patients through referral
- ☐ Accepting new patients through a hospital/facility
- ☐ Not accepting new patients

☐ **CHANGE IN PANEL STATUS**

REQUIREMENTS: Panel changes are effective the date of processing.

PROVIDER TYPE (If applicable, check both)

- ☐ PCP
- ☐ SPECIALIST
- ☐ ECM
- ☐ COMMUNITY SUPPORTS

☐ Open Panel ☐ Closed Panel

- ☐ Accepting new patients
- ☐ Accepting existing patients
- ☐ Accepting new patients through referral
- ☐ Accepting new patients through a hospital/facility
- ☐ Not accepting new patients

☐ **TAX ID CHANGE**

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax ID (required):	Previous Tax ID	New Tax ID

CalOptima Health Addition, Change, Term Form
Revised 03/15, 8/15/17, 10/16, 1/2020, 7/2020, 04/2021

CalOptima Health, A Public Agency

^Optional to answer and not required

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ADD, CHANGE AND TERMINATION (ACT) FORM

ACTION REQUIREMENTS (cont.) (Check all that apply)

☐ TERMINATION

REQUIREMENTS: Complete this form for each provider being terminated from its provider network/ affiliation. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by PDMS and returned to the PR representative.

Effective date (required): ☐ PCP ☐ SPECIALIST ☐ ANCILLARY

Date CalOptima Health received the termination notice:

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider retired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider deceased
- ☐ Provider unwilling to accept member/payment terms
- ☐ Termed due to review action

PCP Termination: Assign member to new PCP: _____
Name of new PCP

Number of members impacted (as of date received): ☐ Medi-Cal _____ ☐ OneCare _____

Date member notice was mailed (if member notice has not been sent, please put anticipated date and notify CalOptima Health if date changes):

Number of days' notice provider gave to MCP:

☐ ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a facility site review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS Check one: [ ] ADD [ ] TERM	Effective Date (required)	SITE TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-Person		
Address		City	State	ZIP
Phone	Fax	Office Hours	After Hours Phone	
Office Manager		Email Address		

SERVICE ADDRESS Check one: [ ] ADD [ ] TERM	Effective Date (required)	SITE TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
Address		City	State	Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number	
Office Manager		Email Address		

☐ LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages spoken by Provider, if fluent with communicating about medical care, put an asterisk next to the language (* Language fluency is optional to disclose and not required)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Language services, such as American Sign Language (ASL) and interpreter services
Check all that apply:

- ☐ In-office ASL interpreter
- ☐ In-office medical interpreter
- ☐ Other type of in-office interpreter service, fill in here _____

☐ Race/Ethnicity

^ Race/ethnicity of provider. Check all that apply:

- ☐ American Indian Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Choose not to share

☐ OTHER

Comments:

PROVIDER RELATIONS REPRESENTATIVE
(Please print)

PROVIDER NAME
(Please print)

SIGNATURE	DATE

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^Optional to answer and not required

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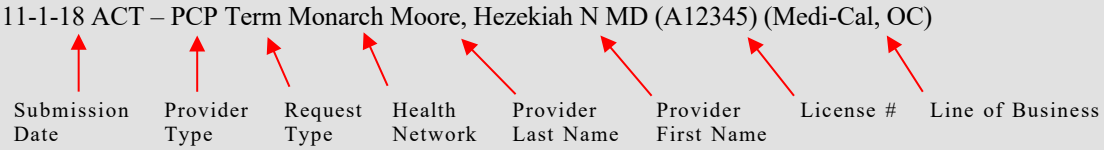
ADDENDUM

CalOptima Health requests use of the email header naming convention reflected below to ensure compliance with turnaround guidelines. Please use the headers below; do not add "Urgent" or deviate from the headers below.

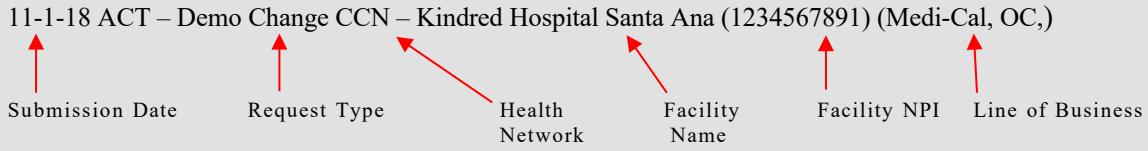
Naming Convention for Email Subject Headers

Provider



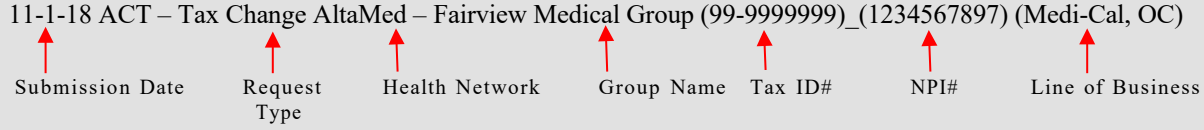
Provider email subject header naming convention:
Submission Date: Date form is submitted
Provider Type: PCP, SPC, MIDLEVEL, ANC
Request Type: Add, Change, Term, CAP (Corrective Action Plan)
Health Network Name: Provider health network affiliation
Provider Last Name: Last name of provider based on state license
Provider First Name: First name of provider based on state license
License #: State license number
Line of Business: MC = Medi-Cal, OC = OneCare

Facility



Facility email subject header naming convention:
Submission Date: Date form is submitted
Request Type: Add, Change, Term, CAP (Corrective Action Plan)
Health Network Name: Facility health network affiliation Facility
Name: Facility name as reflected on agreement
Facility NPI: Facility NPI
Line of Business: MC = Medi-Cal, OC = OneCare

Group



Group Email Subject Header Naming Convention:
Submission Date: Date form is submitted
Request Type: Add, Change, Term, CAP (Corrective Action Plan)
Health Network Name: Provider's health network affiliation
Group Name: Name of group as reflected on agreement
Tax-ID: Group Tax ID on accompanying W-9
NPI #: Type 2 NPI

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CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

DEFINITIONS

HEALTH NETWORK NAME	Health network group name
LINE OF BUSINESS	The program/product code the practitioner affiliates with CalOptima Health at the practice location. Lines of business codes include: MC = Medi-Cal; OC = OneCare; PACE = PACE. If practitioner has more than one program, insert additional line of business records (rows) for each program.
CA LICENSE NUMBER	California license number of the practitioner. Catenate the license type letter (NP, CNM and PA for mid-level; A, C, G, and 20A for MD and DO; E for DPM) and license number together and no space in between.
PROVIDER TIN	The individual federal tax ID of the practitioner. Note: It is NOT a provider group, IPA or location's TIN. Numbers only - no space and no special characters.
TYPE 1 NPI	National provider identifier of the practitioner (NPI type 1, 10 digits).
PROVIDER ID	The individual identification number assigned by CalOptima to be used for existing providers for demographic changes and terminations (9 digits = solo practitioner; 12 digits = affiliated to a group).
MEDICARE NUMBER	CMS Certification Number is used to verify that a provider has been Medicare-/Medicaid-certified and for what type of services. Formerly it was known as 1) OSCAR provider number 2) Medicare Identification Number or 3) Medicare/Medicaid Identification Number. Reference: CMS Manual System, Pub 100-07 State Operations Provider Certification.
MEDI-CAL EFFECTIVE DATE	Effective date the provider received a Medicaid provider number.
PROVIDER LAST NAME	Full last name attached to the practitioner's professional license issued by the State of California. For practitioners not subject to state licensure, such as certain qualified autism service providers, it means the last name appearing on the certification by a national entity.
PROVIDER FIRST NAME	Full first name attached to the practitioner's professional license issued by the State of California. For practitioners not subject to state licensure, such as certain qualified autism service providers, it means the first name appearing on the certification by a national entity.
PROVIDER MIDDLE NAME	Full middle name attached to the practitioner's professional license issued by the State of California. For practitioners not subject to state licensure, such as certain qualified autism service providers, it means the middle name appearing on the certification by a national entity.
TAXONOMY (PRIMARY, SECONDARY, TERTIARY)	The taxonomy code of the specialty for which the practitioner has. Please refer to the taxonomy crosswalk provided by CalOptima Health.
FACILITY PHYSICAL ACCESSIBILITY COMPLIANCE	Meets facility American Disability Act (ADA) handicapped compliance.
ORDERING, REFERRING, PRESCRIBING (ORP)	State or federal regulated certification for providers who order, refer or prescribe.
AREA OF FOCUS	The specific focus of the practitioner's specialty.
PRIMARY SPECIALTY	The primary specialty for which the practitioner is contracted to provide services at the location. When providers practice at multiple sites, they may have different primary and secondary specialties for each site based on the contract.

SECONDARY SPECIALTY	The secondary specialty for which the practitioner is contracted to provide services at the location. When providers practice at multiple sites, they may have different primary and secondary specialties for each site based on the contract.
GROUP NAME	Full name of Medical Group practitioner is affiliated with based on contract.
GROUP/TYPE 2 NPI	National provider identifier of the medical group (NPI type 2, 10 digits).
GROUP ID	The identification number assigned by CalOptima Health to be used for existing medical groups for demographic changes and terminations (nine digits).
GROUP TIN	The group federal tax ID of the practitioner. Numbers only — no space and no special characters.
SERVICE LOCATION STREET	USPS CASS-certified delivery address street names and their ranges at the practice location. Must use USPS postal addressing standard (Publication 28). No special characters. No punctuation unless a decimal in number (39.2 RD), fractional addresses (39 1/2 RD) or hyphenated addresses (39-3 RD). A space between secondary designator and range: APT = Apartment; BLDG = Building; FL = Floor; STE = Suite; UNIT = Unit; RM = Room; DEPT = Department.
SERVICE LOCATION CITY	City where the practice location is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).
SERVICE LOCATION COUNTY	County where the practice is located.
SERVICE LOCATION STATE	State where the practice is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication28)
SERVICE LOCATION ZIP	Zip code in which the practice is located (five digits). Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).
SECONDARY SPECIALTY	The secondary specialty for which the practitioner is contracted to provide services at the location. When providers practice at multiple sites, they may have different primary and secondary specialties for each site based on the contract.
REMIT STREET	USPS CASS-certified pay-to address street names, secondary address unit designators and their ranges for this practice location. Must use USPS postal addressing standard (Publication 28). No special characters. No punctuation unless a decimal in number (39.2 RD), fractional addresses (39 1/2 RD) or hyphenated addresses (39-3 RD). A space between secondary designator and range: APT = Apartment; BLDG = Building; FL = Floor; STE = Suite; UNIT = Unit; RM = Room; DEPT = Department.
REMIT CITY	City where the pay-to is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).
REMIT STATE	State where the pay-to is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).
REMIT ZIP	Zip code in which the pay-to is located (five digits). Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).
OFFICE MANAGER	Name of the contact person at the practice location.
PHONE NUMBER	Phone number at practice location. No space or special character and 10-digit number only.
FAX NUMBER	Fax number at practice location. No space or special character and 10-digit number only.
PUBLIC EMAIL	Email address the practitioner would like to be published on the directory for inquiries from CalOptima Health members. Note: It is NOT site contact person's email.
ADMINISTRATION EMAIL ADDRESS	Email address the practitioner uses for business correspondence with CalOptima Health only. Note: It is NOT site contact person's email. It is internal use between CalOptima Health and practitioner only.

WEBSITE URL ADDRESS	The website or other online resource for the practice location. Use complete URL syntax including scheme, 2 slashes, authority part and path, with optional query and fragment.
SPECIAL SERVICES	Check all that apply: CCS, CPSP
HOSPITAL / FACILTIY AFFILIATIONS ADMITTING PRIV	The name of CalOptima Health-contracted hospital where the practitioner him/herself is on staff and/or having admitting privilege. Type of privileges includes: NONE, ACTIVE, ASSOCIATE STAFF, HONORARY, CONSULTANT, COURTESY, LIMITED, PROVISIONAL, SENIOR ATTENDING, SURGICAL, SUSPENDED.
ATTESTATION	Yes = HN has received a provider attestation. No = HN has not received a provider attestation. Note it won't be published in provider directory now, but by providing the public email, the provider acknowledges and agrees that the email is for patient communications, regularly monitored, maintained in manner consistent with state and federal health privacy laws, including Health Insurance Portability and Accountability Act (HIPAA) and Confidentiality of Medical Information Act (CMIA).
ACCEPTING NEW PATIENTS	Accepting new patients; No = Not accepting new patients
ACCEPTING EXISTING PATIENTS	Accepting existing patients; No = Not accepting existing patients
ACCEPTING THROUGH REFERRAL	Accepting through referral; No = Not accepting through referral
ACCEPTING THROUGH HOSPITAL FACILITY	Accepting through hospital facility; No = Not accepting through referral
NOT ACCEPTING NEW PATIENTS	Not accepting new patients
PANEL STATUS	The providers panel status is "Open" or "Closed".
OFFICE HOUR SUNDAY	Office hours of the practice location on Sunday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR MONDAY	Office hours of the practice location on Monday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR TUESDAY	Office hours of the practice location on Tuesday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR WEDNESDAY	Office hours of the practice location on Wednesday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR THURSDAY	Office hours of the practice location on Thursday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR FRIDAY	Office hours of the practice location on Friday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR SATURDAY	Office hours of the practice location on Saturday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
SERVICE LOCATION PHONE AFTER-HOURS	Phone number at practice location after hours in case of emergency or urgency. No space or special character and 10-digit number only.
STAFF LANGUAGE	The language spoken by office staff (not providers) at practice location. Use Language tab.

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PRACTITIONER LANGUAGE	The language practitioner speaks. Use Language tab.
MEMBER AGE MIN	Use comments section: CalOptima Health member's minimum age that is allowed at the practice location based on provider's contracted specialty. Age is presented in year and no
MEMBER AGE MAX	Use comments section: CalOptima Health member's maximum age that is allowed at the practice location based on provider's contracted specialty. Age is presented in year and no limit = 150.
GENDER RESTRICTION	Use comments section: If the service at the practice location is only accessible to specific gender of CalOptima Health member. F = female member only; M = male member only; NR = no restriction.
TELEHEALTH SITE INDICATORS	Site indicator: Telehealth Only, No Telehealth, or Both Telehealth and In-Person. Use Telehealth Tab.
RACE/ETHNICITY	The Race/Ethnicity of the Provider

Health Care Provider Taxonomy

VERSION 24.0
January 2024

Allopathic & Osteopathic Physicians

Allergy & Immunology

207K00000X Allergy & Immunology Physician

An allergist-immunologist is trained in evaluation, physical and laboratory diagnosis, and management of disorders involving the immune system. Selected examples of such conditions include asthma, anaphylaxis, rhinitis, eczema, and adverse reactions to drugs, foods, and insect stings as well as immune deficiency diseases (both acquired and congenital), defects in host defense, and problems related to autoimmune disease, organ transplantation, or malignancies of the immune system.

Source: American Board of Medical Specialties, 2007, www.abms.org [7/1/2007: added definition, added source] Additional Resources: American Board of Allergy and Immunology, 2007. http://www.abai.org/ No subspecialty certificates in allergy and immunology are offered by the American Board of Allergy and Immunology (ABAI). The ABAI, however, does offer formal special pathways for physicians seeking dual certification in allergy/immunology and pediatric pulmonology; allergy/immunology and pediatric rheumatology; and allergy/immunology and adult rheumatology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Allergy

207KA0200X Allergy Physician

A physician who specializes in the diagnosis, treatment, and management of allergies.

Source: National Uniform Claim Committee

Effective Date 4/1/2003 Last Modified Date 1/1/2023

Specialization: Clinical & Laboratory Immunology

207KI0005X Clinical & Laboratory Immunology (Allergy & Immunology) Physician

An allergy and immunology physician who specializes in clinical and laboratory immunology disease management..

Source: National Uniform Claim Committee, 2022
Additional Resources: A certification was, but is no longer, issued by the American Board of Allergy and Immunology.

Effective Date 4/1/2003 Last Modified Date 1/1/2023

Allopathic & Osteopathic Physicians

Anesthesiology

207L00000X Anesthesiology Physician

An anesthesiologist is trained to provide pain relief and maintenance, or restoration, of a stable condition during and immediately following an operation or an obstetric or diagnostic procedure. The anesthesiologist assesses the risk of the patient undergoing surgery and optimizes the patient's condition prior to, during and after surgery. In addition to these management responsibilities, the anesthesiologist provides medical management and consultation in pain management and critical care medicine. Anesthesiologists diagnose and treat acute, long-standing and cancer pain problems; diagnose and treat patients with critical illnesses or severe injuries; direct resuscitation in the care of patients with cardiac or respiratory emergencies, including the need for artificial ventilation; and supervise post-anesthesia recovery.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Anesthesiology, 2007. http://www.theaba.org/; American Osteopathic Board of Anesthesiology, 2007, http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Anesthesiology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Anesthesiology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Addiction Medicine

207LA0401X Addiction Medicine (Anesthesiology) Physician

An anesthesiologist who specializes in the diagnosis and treatment of addictions.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added]
Additional Resources: A Certification of Added Qualifications (CAQ) was, but is no longer issued by the American Osteopathic Board of Anesthesiology.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Critical Care Medicine

207LC0200X Critical Care Medicine (Anesthesiology) Physician

An anesthesiologist, who specializes in critical care medicine diagnoses, treats and supports patients with multiple organ dysfunction. This specialist may have administrative responsibilities for intensive care units and may also facilitate and coordinate patient care among the primary physician, the critical care staff and other specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Anesthesiology, 2007. http://www.theaba.org/; American Osteopathic Board of Anesthesiology, 2007, http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Anesthesiology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Anesthesiology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Anesthesiology

Specialization: Hospice and Palliative Medicine

207LH0002X Hospice and Palliative Medicine (Anesthesiology) Physician

An anesthesiologist with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Specialization: Pain Medicine

207LP2900X Pain Medicine (Anesthesiology) Physician

An anesthesiologist who provides a high level of care, either as a primary physician or consultant, for patients experiencing problems with acute, chronic and/or cancer pain in both hospital and ambulatory settings. Patient care needs are also coordinated with other specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Anesthesiology, 2007. http://www.theaba.org/; American Osteopathic Board of Anesthesiology, 2007, http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Anesthesiology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Anesthesiology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Pediatric Anesthesiology

207LP3000X Pediatric Anesthesiology Physician

An anesthesiologist who has had additional skill and experience in and is primarily concerned with the anesthesia, sedation, and pain management needs of infants and children. A pediatric anesthesiologist generally provides services including the evaluation of complex medical problems in infants and children when surgery is necessary, planning and care for children before and after surgery, pain control, anesthesia and sedation for any procedures out of the operating room such as MRI, CT scan, and radiation therapy.

Source: American Academy of Pediatrics, www.aap.org [7/1/2006: new]

Effective Date 10/1/2006

Allopathic & Osteopathic Physicians

Clinical Pharmacology

208U00000X Clinical Pharmacology Physician

Clinical pharmacology encompasses the spectrum of activities related to the discovery, development, regulation, and utilization of safe and effective drugs.

Source: American Society for Clinical Pharmacology and Therapeutics, 2008 [7/1/2008: modified definition] Additional Resources: Clinical pharmacology is a recognized fellowship program for physicians, pharmacists, and post-doctoral researchers delivered through medical education institutions accredited by the American Board of Clinical Pharmacology. http://www.ascpt.org/; American Board of Clinical Pharmacology http://www.abcp.net/

Effective Date 4/1/2003

Colon & Rectal Surgery

208C00000X Colon & Rectal Surgery Physician

A colon and rectal surgeon is trained to diagnose and treat various diseases of the intestinal tract, colon, rectum, anal canal and perianal area by medical and surgical means. This specialist also deals with other organs and tissues (such as the liver, urinary and female reproductive system) involved with primary intestinal disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source] Additional Resources: American Board of Colon and Rectal Surgery, 2007. http://www.abcrs.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Colon and Rectal Surgery. Colon and rectal surgeons have the expertise to diagnose and often manage anorectal conditions such as hemorrhoids, fissures (painful tears in the anal lining), abscesses and fistulae (infections located around the anus and rectum) in the office setting. They also treat problems of the intestine and colon, and perform endoscopic procedures to evaluate and treat problems such as cancer, polyps (precancerous growths) and inflammatory conditions.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Dermatology

207N00000X Dermatology Physician

A dermatologist is trained to diagnose and treat pediatric and adult patients with benign and malignant disorders of the skin, mouth, external genitalia, hair and nails, as well as a number of sexually transmitted diseases. The dermatologist has had additional training and experience in the diagnosis and treatment of skin cancers, melanomas, moles and other tumors of the skin, the management of contact dermatitis and other allergic and nonallergic skin disorders, and in the recognition of the skin manifestations of systemic (including internal malignancy) and infectious diseases. Dermatologists have special training in dermatopathology and in the surgical techniques used in dermatology. They also have expertise in the management of cosmetic disorders of the skin such as hair loss and scars and the skin changes associated with aging.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source] Additional Resources: American Board of Dermatology, 2007. http://www.abderm.org/ Board certification is provided by the American Board of Dermatology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Dermatology

Specialization: Clinical & Laboratory Dermatological Immunology

207NI0002X Clinical & Laboratory Dermatological Immunology Physician

A dermatologist who utilizes various specialized laboratory procedures to diagnose disorders characterized by defective responses of the body's immune system. Immunodermatologists also may provide consultation in the management of these disorders and administer specialized forms of therapy for these diseases.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source] Additional Resources: American Board of Dermatology, 2007. http://www.abderm.org/ Board certification is provided by the American Board of Dermatology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Dermatopathology

207ND0900X Dermatopathology Physician

A dermatopathologist has the expertise to diagnose and monitor diseases of the skin including infectious, immunologic, degenerative and neoplastic diseases. This entails the examination and interpretation of specially prepared tissue sections, cellular scrapings and smears of skin lesions by means of routine and special (electron and fluorescent) microscopes.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Dermatology, 2007. http://www.abderm.org/; American Osteopathic Board of Dermatology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Dermatology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Dermatology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: MOHS-Micrographic Surgery

207ND0101X MOHS-Micrographic Surgery Physician

The highly-trained surgeons that perform Mohs Micrographic Surgery are specialists both in dermatology and pathology. With their extensive knowledge of the skin and unique pathological skills, they are able to remove only diseased tissue, preserving healthy tissue and minimizing the cosmetic impact of the surgery. Mohs surgeons who belong to the American College of Mohs Surgery (ACMS) have completed a minimum of one year of fellowship training at one of the ACMS-approved training centers in the U.S.

Source: American College of Mohs Surgery, 2007 [1/1/2008: added definition, added source] Additional Resources: Additional Resources: http://www.mohscollege.org/; American Board of Dermatology, 2007. http://www.abderm.org/

Effective Date 4/1/2003 Last Modified Date 1/1/2008

Allopathic & Osteopathic Physicians

Dermatology

Specialization: Pediatric Dermatology

207NP0225X Pediatric Dermatology Physician

A pediatric dermatologist has, through additional special training, developed expertise in the treatment of specific skin disease categories with emphasis on those diseases which predominate in infants, children and adolescents.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: changed definition, added source] Additional Resources: American Board of Dermatology, 2007, http://www.abderm.org/ A subspecialty certificate was approved by ABMS in 2000. ACGME Accredited Residency Program Requirements: None.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Procedural Dermatology

207NS0135X Procedural Dermatology Physician

Procedural Dermatology, a subspecialty of Dermatology, encompassing a wide variety of surgical procedures and methods to remove or modify skin tissue for health or cosmetic benefit. These methods include scalpel surgery, laser surgery, chemical surgery, cryosurgery (liquid nitrogen), electrosurgery, aspiration surgery, liposuction, injection of filler substances, and Mohs micrographic controlled surgery (a special technique for the removal of growths, especially skin cancers).

Source: American Board of Dermatology, 2007, www.abderm.org [1/1/2008: definition added, source added, title changed] Additional Resources: Some ABMS board certified dermatologists have completed a one-year ACGME approved fellowship in Procedural Dermatology, which has been offered since 2003. At this time the ABD does not offer subspecialty certification in Procedural Dermatology.

Effective Date 4/1/2003 Last Modified Date 1/1/2008

Electrodiagnostic Medicine

204R00000X Electrodiagnostic Medicine Physician

Electrodiagnostic medicine is the medical subspecialty that applies neurophysiologic techniques to diagnose, evaluate, and treat patients with impairments of the neurologic, neuromuscular, and/or muscular systems. Qualified physicians are trained in performing electrophysiological testing and interpretation of the test data. They require knowledge in anatomy, physiology, kinesiology, histology, and pathology of the brain, spinal cord, autonomic nerves, cranial nerves, peripheral nerves, neuromuscular junction, and muscles. They must know clinical features and treatment of diseases of the central, peripheral, and autonomic nervous systems, as well as those of neuromuscular junction and muscle. Physicians also require special knowledge about electric signal processing, including waveform analysis, electronics and instrumentation, stimulation and recording equipment, and statistics.

Source: American Association of Neuromuscular & Electrodiagnostic Medicine, 2011. www.aanem.org [1/1/2011: new] Additional Resources: American Board of Electrodiagnostic Medicine, 2011. www.abemexam.org

Effective Date 4/1/2011

Allopathic & Osteopathic Physicians

Emergency Medicine

207P00000X Emergency Medicine Physician

An emergency physician focuses on the immediate decision making and action necessary to prevent death or any further disability both in the pre-hospital setting by directing emergency medical technicians and in the emergency department. The emergency physician provides immediate recognition, evaluation, care, stabilization and disposition of a generally diversified population of adult and pediatric patients in response to acute illness and injury.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Emergency Medicine, 2007. http://www.abem.org/public/; American Osteopathic Board of Emergency Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Emergency Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Emergency Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Emergency Medical Services

207PE0004X Emergency Medical Services (Emergency Medicine) Physician

An emergency medicine physician who specializes in non-hospital based emergency medical services (e.g., disaster site, accident scene, transport vehicle, etc.) to provide pre-hospital assessment, treatment, and transport patients.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added]
Additional Resources: A Certification of Added Qualifications (CAQ) is issued by the American Osteopathic Board of Emergency Medicine.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Hospice and Palliative Medicine

207PH0002X Hospice and Palliative Medicine (Emergency Medicine) Physician

An emergency medicine physician with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Allopathic & Osteopathic Physicians

Emergency Medicine

Specialization: Medical Toxicology

207PT0002X Medical Toxicology (Emergency Medicine) Physician

Medical toxicologists are physicians who specialize in the prevention, evaluation, treatment and monitoring of injury and illness from exposures to drugs and chemicals, as well as biological and radiological agents. Medical toxicologists care for people in clinical, academic, governmental and public health settings, and provide poison control center leadership. Important areas of medical toxicology include acute drug poisoning, adverse drug events, drug abuse, addiction and withdrawal, chemicals and hazardous materials, terrorism preparedness, venomous bites and stings and environmental and workplace exposures.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Emergency Medicine, 2007. http://www.abem.org/public/. American Osteopathic Board of Emergency Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Emergency Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Emergency Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Pediatric Emergency Medicine

207PP0204X Pediatric Emergency Medicine (Emergency Medicine) Physician

Pediatric Emergency Medicine is a clinical subspecialty that focuses on the care of the acutely ill or injured child in the setting of an emergency department.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source] Additional Resources: American Board of Emergency Medicine, 2007. http://www.abem.org/public/ Board certification is provided by the American Board of Emergency Medicine. Board certification for Medical Doctors (MDs) is provided by the American Board of Emergency Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Emergency Medicine

Specialization: Sports Medicine

207PS0010X Sports Medicine (Emergency Medicine) Physician

An emergency physician with special knowledge in sports medicine is responsible for continuous care in the field of sports medicine, not only for the enhancement of health and fitness, but also for the prevention and management of injury and illness. A sports medicine physician has knowledge and experience in the promotion of wellness and the role of exercise in promoting a healthy lifestyle. Knowledge of exercise physiology, biomechanics, nutrition, psychology, physical rehabilitation and epidemiology is essential to the practice of sports medicine.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Emergency Medicine, 2007. http://www.abem.org/public/. American Osteopathic Board of Emergency Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Emergency Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Emergency Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Undersea and Hyperbaric Medicine

207PE0005X Undersea and Hyperbaric Medicine (Emergency Medicine) Physician

A specialist who treats decompression illness and diving accident cases and uses hyperbaric oxygen therapy to treat such conditions as carbon monoxide poisoning, gas gangrene, non-healing wounds, tissue damage from radiation and burns, and bone infections. This specialist also serves as a consultant to other physicians in all aspects of hyperbaric chamber operations, and assesses risks and applies appropriate standards to prevent disease and disability in divers and other persons working in altered atmospheric conditions.

Source: American Board of Emergency Medicine [7/1/2008: source added, additional resources added] Additional Resources: Additional Resources: www.abem.org & American Board of Preventive Medicine www.abprevmed.org

Effective Date 4/1/2003

Allopathic & Osteopathic Physicians

Family Medicine

207Q00000X Family Medicine Physician

Family Medicine is the medical specialty which is concerned with the total health care of the individual and the family. It is the specialty in breadth which integrates the biological, clinical, and behavioral sciences. The scope of family medicine is not limited by age, sex, organ system, or disease entity.

Source: American Board of Family Medicine [1/1/2007: changed title; 7/1/2007: added definition, added source; 7/1/2017: modified definition]

Note: The American Osteopathic Board of Family Physicians certification includes extensive use of Osteopathic Manipulative Treatment (OMT), which integrates the biological, clinical, and behavioral sciences.

Additional Resources: American Board of Family Medicine, www.theabfm.org. American Osteopathic Board of Family Physicians, www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Family Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Family Physicians or the American Board of Family Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Addiction Medicine

207QA0401X Addiction Medicine (Family Medicine) Physician

A family medicine physician who specializes in the diagnosis and treatment of addictions.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added]
Additional Resources: A Certification of Added Qualifications (CAQ) was, but is no longer issued by the American Osteopathic Board of Family Physicians.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Adolescent Medicine

207QA0000X Adolescent Medicine (Family Medicine) Physician

A family medicine physician with multidisciplinary training in the unique physical, psychological and social characteristics of adolescents and their health care problems and needs.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Family Medicine, 2007. http://www.theabfm.org/. American Osteopathic Board of Family Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Family Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Family Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Family Medicine

Specialization: Adult Medicine

207QA0505X **Adult Medicine Physician**

The NUCC recommends this code not be used. Choose a more appropriate code.

#Type!

Effective Date 4/1/2003 Last Modified Date 1/1/2023

Specialization: Geriatric Medicine

207QG0300X **Geriatric Medicine (Family Medicine) Physician**

A family medicine physician with special knowledge of the aging process and special skills in the diagnostic, therapeutic, preventive and rehabilitative aspects of illness in the elderly. This specialist cares for geriatric patients in the patient's home, the office, long-term care settings such as nursing homes, and the hospital.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Family Medicine, 2007. http://wwwtheabfm.org/. American Osteopathic Board of Family Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Family Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Family Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Hospice and Palliative Medicine

207QH0002X **Hospice and Palliative Medicine (Family Medicine) Physician**

A family medicine physician with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Allopathic & Osteopathic Physicians

Family Medicine

Specialization: Obesity Medicine

207QB0002X Obesity Medicine (Family Medicine) Physician

A physician who specializes in the treatment of obesity demonstrates competency in and a thorough understanding of the treatment of obesity and the genetic, biologic, environmental, social, and behavioral factors that contribute to obesity. The obesity medicine physician employs therapeutic interventions including diet, physical activity, behavioral change, and pharmacotherapy. The obesity medicine physician utilizes a comprehensive approach, and may include additional resources such as dietitians, exercise physiologists, mental health professionals and bariatric surgeons as indicated to achieve optimal results. Additionally, the obesity medicine physician maintains competency in providing pre- peri- and post-surgical care of bariatric surgery patients, promotes the prevention of obesity, and advocates for those who suffer from obesity.

Source: American Board of Obesity Medicine, www.abom.org [10/1/2007: new, 7/1/2015: title and definition modified] Additional Resource: American Society of Bariatric Physicians, www.asbp.org.

Effective Date 10/1/2007

Specialization: Sleep Medicine

207QS1201X Sleep Medicine (Family Medicine) Physician

A Family Medicine Physician who practices Sleep Medicine is certified in the subspecialty of sleep medicine and specializes in the clinical assessment, physiologic testing, diagnosis, management and prevention of sleep and circadian rhythm disorders. Sleep specialists treat patients of any age and use multidisciplinary approaches. Disorders managed by sleep specialists include, but are not limited to, sleep related breathing disorders, insomnia, hypersomnias, circadian rhythm sleep disorders, parasomnias and sleep related movement disorders.

Source: American Academy of Sleep Medicine, 2008, www.aasm.org [7/1/2008: new]

Effective Date 10/1/2008

Specialization: Sports Medicine

207QS0010X Sports Medicine (Family Medicine) Physician

A family medicine physician that is trained to be responsible for continuous care in the field of sports medicine, not only for the enhancement of health and fitness, but also for the prevention of injury and illness. A sports medicine physician must have knowledge and experience in the promotion of wellness and the prevention of injury. Knowledge about special areas of medicine such as exercise physiology, biomechanics, nutrition, psychology, physical rehabilitation, epidemiology, physical evaluation, injuries (treatment and prevention and referral practice) and the role of exercise in promoting a healthy lifestyle are essential to the practice of sports medicine. The sports medicine physician requires special education to provide the knowledge to improve the health care of the individual engaged in physical exercise (sports) whether as an individual or in team participation.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Family Medicine, 2007. http://www.theabfm.org/. American Osteopathic Board of Family Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Family Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Family Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

General Practice

208D00000X General Practice Physician

A physician who specializes in the general practice of diagnosing, treating, and managing patients with a variety of illnesses and conditions.

Source: National Uniform Claim Committee

Effective Date 4/1/2003 Last Modified Date 1/1/2023

Hospitalist

208M00000X Hospitalist Physician

Hospitalists are physicians whose primary professional focus is the general medical care of hospitalized patients. Their activities include patient care, teaching, research, and leadership related to Hospital Medicine. The term 'hospitalist' refers to physicians whose practice emphasizes providing care for hospitalized patients.

Source: American Society of Hospital Medicine, 2007. http://www.hospitalmedicine.org/ [7/1/2009: definition added] Additional Resources: Hospitalist is a recognized fellowship specialty program offered by many medical institutions. There is no board certification for the specialty at this point.

Effective Date 4/1/2003

Independent Medical Examiner

202C00000X Independent Medical Examiner Physician

A special evaluator not involved with the medical care of the individual examinee that impartially evaluates the care being provided by other practitioners to clarify clinical, disability, liability or other case issues.

Source: American Board of Independent Medical Examiners, www.abime.org [1/1/2007: new]

Effective Date 4/1/2007

Integrative Medicine

202D00000X Integrative Medicine Physician

A physician who specializes in the treatment of the whole person through prevention and treatment based on medical evidence. Integrative medicine considers all factors that influence health, wellness, and disease - including mind, body, and spirit. Conventional and alternative methods are used to facilitate the body's innate healing response. Appropriate consideration is given to use of less-invasive and less-harmful interventions, when possible. It also incorporates all appropriate therapeutic approaches, health care modalities, and disciplines to achieve optimal health and healing.

Source: American Board of Physician Specialties, www.abpsus.org/aboim

Effective Date 4/1/2022

Allopathic & Osteopathic Physicians

Internal Medicine

207R00000X Internal Medicine Physician

A physician who provides long-term, comprehensive care in the office and the hospital, managing both common and complex illness of adolescents, adults and the elderly. Internists are trained in the diagnosis and treatment of cancer, infections and diseases affecting the heart, blood, kidneys, joints and digestive, respiratory and vascular systems. They are also trained in the essentials of primary care internal medicine, which incorporates an understanding of disease prevention, wellness, substance abuse, mental health and effective treatment of common problems of the eyes, ears, skin, nervous system and reproductive organs.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Addiction Medicine

207RA0401X Addiction Medicine (Internal Medicine) Physician

An internist doctor of osteopathy that specializes in the treatment of addiction disorders. A doctor of osteopathy that is board eligible/certified by the American Osteopathic Board of Internal Medicine can obtain a Certificate of Added Qualifications in the field of Addiction Medicine.

Source: American Osteopathic Board of Internal Medicine, 2007. [7/1/2008: added definition, added source; 7/1/2011: modified source]

Additional Resources: http://www.osteopathic.org/certification

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Adolescent Medicine

207RA0000X Adolescent Medicine (Internal Medicine) Physician

An internist who specializes in adolescent medicine is a multi-disciplinary healthcare specialist trained in the unique physical, psychological and social characteristics of adolescents, their healthcare problems and needs.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Adult Congenital Heart Disease

207RA0002X Adult Congenital Heart Disease Physician

A physician who specializes in the care and treatment of adults with congenital heart disease. Adult congenital heart disease (ACHD) physicians are trained to understand the complexities of congenital heart disease, anatomy, physiology, surgical repairs, and long-term complications and use that to manage ACHD with acquired heart disease, including heart failure, arrhythmias, and pulmonary hypertension.

Source: American College of Cardiology, www.acc.org [7/1/2018: new]

Effective Date 10/1/2018

Specialization: Advanced Heart Failure and Transplant Cardiology

207RA0001X Advanced Heart Failure and Transplant Cardiology Physician

Specialists in Advanced Heart Failure and Transplant Cardiology would participate in the inpatient and outpatient management of patients with advanced heart failure across the spectrum from consideration for high-risk cardiac surgery, cardiac transplantation, or mechanical circulatory support, to pre-and post-operative evaluation and management of patients with cardiac transplants and mechanical support devices, and end-of-life care for patients with end-stage heart failure.

Source: American Board of Internal Medicine, www.abim.org [7/1/2015: new]

Effective Date 10/1/2015

Specialization: Allergy & Immunology

207RA0201X Allergy & Immunology (Internal Medicine) Physician

An internist doctor of osteopathy that specializes in the treatment of allergy and immunologic disorders. A doctor of osteopathy that is board eligible/certified by the American Osteopathic Board of Internal Medicine can obtain a Certificate of Special Qualifications in the field of Allergy & Immunology.

Source: American Osteopathic Board of Internal Medicine, 2007. [7/1/2008: added definition, added source; 7/1/2011: modified source]

Additional Resources: http://www.osteopathic.org/certification

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Cardiovascular Disease

207RC0000X Cardiovascular Disease Physician

An internist who specializes in diseases of the heart and blood vessels and manages complex cardiac conditions such as heart attacks and life-threatening, abnormal heartbeat rhythms.

Source: American Osteopathic Board of Internal Medicine, 2008 [7/1/2008: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, http://www.abim.org/. American Osteopathic Board of Internal Medicine, https://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Clinical & Laboratory Immunology

207RI0001X Clinical & Laboratory Immunology (Internal Medicine) Physician

An internal medicine physician who specializes in clinical and laboratory immunology disease management.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added]
Additional Resources: A certification was, but is no longer issued by the American Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Clinical Cardiac Electrophysiology

207RC0001X Clinical Cardiac Electrophysiology Physician

A field of special interest within the subspecialty of cardiovascular disease, specialty of Internal Medicine, which involves intricate technical procedures to evaluate heart rhythms and determine appropriate treatment for them.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Critical Care Medicine

207RC0200X Critical Care Medicine (Internal Medicine) Physician

An internist who diagnoses, treats and supports patients with multiple organ dysfunction. This specialist may have administrative responsibilities for intensive care units and may also facilitate and coordinate patient care among the primary physician, the critical care staff and other specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Endocrinology, Diabetes & Metabolism

207RE0101X Endocrinology, Diabetes & Metabolism Physician

An internist who concentrates on disorders of the internal (endocrine) glands such as the thyroid and adrenal glands. This specialist also deals with disorders such as diabetes, metabolic and nutritional disorders, obesity, pituitary diseases and menstrual and sexual problems.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Gastroenterology

207RG0100X Gastroenterology Physician

An internist who specializes in diagnosis and treatment of diseases of the digestive organs including the stomach, bowels, liver and gallbladder. This specialist treats conditions such as abdominal pain, ulcers, diarrhea, cancer and jaundice and performs complex diagnostic and therapeutic procedures using endoscopes to visualize internal organs.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Geriatric Medicine

207RG0300X Geriatric Medicine (Internal Medicine) Physician

An internist who has special knowledge of the aging process and special skills in the diagnostic, therapeutic, preventive and rehabilitative aspects of illness in the elderly. This specialist cares for geriatric patients in the patient's home, the office, long-term care settings such as nursing homes and the hospital.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Hematology

207RH0000X Hematology (Internal Medicine) Physician

An internist with additional training who specializes in diseases of the blood, spleen and lymph. This specialist treats conditions such as anemia, clotting disorders, sickle cell disease, hemophilia, leukemia and lymphoma.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Hematology & Oncology

207RH0003X Hematology & Oncology Physician

An internist doctor of osteopathy that specializes in the treatment of the combination of hematology and oncology disorders. A doctor of osteopathy that is board eligible/certified by the American Osteopathic Board of Internal Medicine WAS able to obtain a Certificate of Special Qualifications in the field of Hematology and Oncology. The Certificate is NO longer offered.

Source: American Osteopathic Board of Internal Medicine, 2007. [7/1/2008: definition added, source added; 7/1/2011: modified source]

Additional Resources: http://www.osteopathic.org/certification

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Hepatology

207RI0008X Hepatology Physician

The discipline of Hepatology encompasses the structure, function, and diseases of the liver and biliary tract. The American Board of Internal Medicine considers Hepatology part of the subspecialty of gastroenterology. Physicians who identify themselves as Hepatologists usually, but not always, have been trained in gastrointestinal programs.

Training Programs, and/or Fellowships, Preceptorships: The American Association for the Study of Liver Diseases (AASLD) is the major professional society organized for physicians with an interest in Hepatology. A subcommittee of that organization has published guidelines for training programs in the 1992 November issue of Hepatology. Source: The American Board of Internal Medicine 9/1993 ACGME Accredited Residency Program Requirements: None

Effective Date 4/1/2003

Specialization: Hospice and Palliative Medicine

207RH0002X Hospice and Palliative Medicine (Internal Medicine) Physician

An internal medicine physician with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Specialization: Hypertension Specialist

207RH0005X Hypertension Specialist Physician

A Hypertension Specialist is a physician who concentrates on all aspects of the diagnosis and treatment of hypertension.

Source: American Society of Hypertension, www.ash-us.org [7/1/2011: new] Additional Resources: The American Society of Hypertension Specialists Program offers an examination and designation for Hypertension Specialists. This subspecialty is not a Board certificate issued by either the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine.

Effective Date 10/1/2011

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Infectious Disease

207RI0200X Infectious Disease Physician

An internist who deals with infectious diseases of all types and in all organ systems. Conditions requiring selective use of antibiotics call for this special skill. This physician often diagnoses and treats AIDS patients and patients with fevers which have not been explained. Infectious disease specialists may also have expertise in preventive medicine and travel medicine.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Interventional Cardiology

207RI0011X Interventional Cardiology Physician

An area of medicine within the subspecialty of cardiology, which uses specialized imaging and other diagnostic techniques to evaluate blood flow and pressure in the coronary arteries and chambers of the heart and uses technical procedures and medications to treat abnormalities that impair the function of the cardiovascular system.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source] Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/ Board Certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. ACGME Accredited Residency Program Requirements: 1 year of training plus a prerequisite of 3 years Internal Medicine, 3 years Cardiovascular Disease for a total of 7 years. ABMS Approved Subspecialty Certificate (Internal Medicine)

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Magnetic Resonance Imaging (MRI)

207RM1200X Magnetic Resonance Imaging (MRI) Internal Medicine Physician

The NUCC recommends this code not be used. Choose a more appropriate code.

#Type!

Effective Date 4/1/2003 Last Modified Date 1/1/2023

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Medical Oncology

207RX0202X Medical Oncology Physician

An internist who specializes in the diagnosis and treatment of all types of cancer and other benign and malignant tumors. This specialist decides on and administers therapy for these malignancies as well as consults with surgeons and radiotherapists on other treatments for cancer.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source. 11/5/2007: corrected definition]

Effective Date 4/1/2003 Last Modified Date 11/5/2007

Specialization: Nephrology

207RN0300X Nephrology Physician

An internist who treats disorders of the kidney, high blood pressure, fluid and mineral balance and dialysis of body wastes when the kidneys do not function. This specialist consults with surgeons about kidney transplantation.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Obesity Medicine

207RB0002X Obesity Medicine (Internal Medicine) Physician

A physician who specializes in the treatment of obesity demonstrates competency in and a thorough understanding of the treatment of obesity and the genetic, biologic, environmental, social, and behavioral factors that contribute to obesity. The obesity medicine physician employs therapeutic interventions including diet, physical activity, behavioral change, and pharmacotherapy. The obesity medicine physician utilizes a comprehensive approach, and may include additional resources such as dietitians, exercise physiologists, mental health professionals and bariatric surgeons as indicated to achieve optimal results. Additionally, the obesity medicine physician maintains competency in providing pre- peri- and post-surgical care of bariatric surgery patients, promotes the prevention of obesity, and advocates for those who suffer from obesity.

Source: American Board of Obesity Medicine, www.abom.org [10/1/2007: new, 7/1/2015: title and definition modified] Additional Resource: American Society of Bariatric Physicians, www.asbp.org.

Effective Date 10/1/2007

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Pulmonary Disease

207RP1001X Pulmonary Disease Physician

An internist who treats diseases of the lungs and airways. The pulmonologist diagnoses and treats cancer, pneumonia, pleurisy, asthma, occupational and environmental diseases, bronchitis, sleep disorders, emphysema and other complex disorders of the lungs.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Rheumatology

207RR0500X Rheumatology Physician

An internist who treats diseases of joints, muscle, bones and tendons. This specialist diagnoses and treats arthritis, back pain, muscle strains, common athletic injuries and "collagen" diseases.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Sleep Medicine

207RS0012X Sleep Medicine (Internal Medicine) Physician

An Internist who practices Sleep Medicine is certified in the subspecialty of sleep medicine and specializes in the clinical assessment, physiologic testing, diagnosis, management and prevention of sleep and circadian rhythm disorders. Sleep specialists treat patients of any age and use multidisciplinary approaches. Disorders managed by sleep specialists include, but are not limited to, sleep related breathing disorders, insomnia, hypersomnias, circadian rhythm sleep disorders, parasomnias and sleep related movement disorders.

Source: American Academy of Sleep Medicine, www.aasm.org [7/1/2006: new]

Effective Date 10/1/2006

Allopathic & Osteopathic Physicians

Internal Medicine

Specialization: Sports Medicine

207RS0010X Sports Medicine (Internal Medicine) Physician

An internist trained to be responsible for continuous care in the field of sports medicine, not only for the enhancement of health and fitness, but also for the prevention of injury and illness. A sports medicine physician must have knowledge and experience in the promotion of wellness and the prevention of injury. Knowledge about special areas of medicine such as exercise physiology, biomechanics, nutrition, psychology, physical rehabilitation, epidemiology, physical evaluation, injuries (treatment and prevention and referral practice) and the role of exercise in promoting a healthy lifestyle are essential to the practice of sports medicine. The sports medicine physician requires special education to provide the knowledge to improve the healthcare of the individual.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: added definition, added source; 7/1/2011: modified source]

Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. American Osteopathic Board of Internal Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Internal Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Transplant Hepatology

207RT0003X Transplant Hepatology Physician

An internist with special knowledge and the skill required of a gastroenterologist to care for patients prior to and following hepatic transplantation that spans all phases of liver transplantation. Selection of appropriate recipients requires assessment by a team having experience in evaluating the severity and prognosis of patients with liver disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: new] Additional Resources: American Board of Internal Medicine, 2007. http://www.abim.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Internal Medicine.

Effective Date 10/1/2007

Allopathic & Osteopathic Physicians

Legal Medicine

209800000X Legal Medicine (M.D./D.O.) Physician

Legal Medicine is a special field of medicine that focuses on various aspects of medicine and law. Historically, the practice of legal medicine made contributions to medicine as a scientific instrument to solve criminal perplexities. Since World War II, the domain of legal medicine has broadened to include not only aspects of medical science to solve legal and criminal problems but aspects of law as it applies to medicine. Legal Medicine continues to grow as medicolegal issues like medical malpractice and liability, government regulation of health care, issues of tort reform, and moral and ethical complexities presented by technological advances become increasingly prominent. Many medical schools have implemented courses which supply medicolegal instruction for medical students, and many law schools now offer medicolegal courses. Also, dual degree programs in law and medicine have been created to assist physicians to bridge the gap between medicine and the law.

Source: American Board of Legal Medicine 08/1992. www.ablminc.org [7/1/2009: definition reformatted] Additional Resources: Training Programs, and/or Fellowships, Preceptorships: Certification available through the American Board of Legal Medicine. ACGME Accredited Residency Program Requirements: None.

Effective Date 4/1/2003

Medical Genetics

Specialization: Clinical Biochemical Genetics

207SG0202X Clinical Biochemical Genetics Physician

A clinical biochemical geneticist demonstrates competence in performing and interpreting biochemical analyses relevant to the diagnosis and management of human genetic diseases and is a consultant regarding laboratory diagnosis of a broad range of inherited disorders.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Medical Genetics, 2007. http://www.abmg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Medical Genetics.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Clinical Cytogenetics

207SC0300X Clinical Cytogenetics Physician

A clinical cytogeneticist demonstrates competence in providing laboratory diagnostic and clinical interpretive services dealing with cellular components, particularly chromosomes, associated with heredity.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Medical Genetics, 2007. http://www.abmg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Medical Genetics. A general certificate was first issued by the ABMS in 1982. ACGME Accredited Residency Program Requirements: None.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Medical Genetics

Specialization: Clinical Genetics (M.D.)

207SG0201X Clinical Genetics (M.D.) Physician

A clinical geneticist demonstrates competence in providing comprehensive diagnostic, management and counseling services for genetic disorders.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Medical Genetics, 2007. http://www.abmg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Medical Genetics.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Clinical Molecular Genetics

207SG0203X Clinical Molecular Genetics Physician

A clinical molecular geneticist demonstrates competence in performing and interpreting molecular analyses relevant to the diagnosis and management of human genetic diseases and is a consultant regarding laboratory diagnosis of a broad range of inherited disorders.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Medical Genetics, 2007. http://www.abmg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Medical Genetics.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Medical Biochemical Genetics

207SG0207X Medical Biochemical Genetics

A medical biochemical geneticist specializes in the diagnosis, evaluation, prevention, and treatment of patients with biochemical genetic disorders, defined as inborn errors of metabolism at any age of onset. Training does not include those skills and knowledge necessary to direct a clinical laboratory.

Source: American Board of Medical Genetics and Genomics, www.abmgg.org. [10/1/2023: New]

Effective Date 10/1/2023

Specialization: Molecular Genetic Pathology

207SM0001X Molecular Genetic Pathology (Medical Genetics) Physician

A board certified subspecialty, the molecular genetic pathologist is expert in the principles, theory and technologies of molecular biology and molecular genetics. This expertise is used to make or confirm diagnoses of Mendelian genetic disorders, of human development, infectious diseases and malignancies and to assess the natural history of those disorders. A molecular genetic pathologist provides information about gene structure, function and alteration, and applies laboratory techniques for diagnosis, treatment and prognosis for individuals with related disorders.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Medical Genetics, 2007. http://www.abmg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Medical Genetics. A subspecialty certificate for MGG was approved by the ABMS in 1999. ACGME Accredited Residency Program Requirements: Proposal under development.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Medical Genetics

Specialization: Ph.D. Medical Genetics

207SG0205X Ph.D. Medical Genetics Physician

A medical geneticist works in association with a medical specialist, is affiliated with a clinical genetics program and serves as a consultant to medical and dental specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Medical Genetics, 2007. http://www.abmg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Medical Genetics.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Neurological Surgery

207T00000X Neurological Surgery Physician

A neurological surgeon provides the operative and non-operative management (i.e., prevention, diagnosis, evaluation, treatment, critical care, and rehabilitation) of disorders of the central, peripheral, and autonomic nervous systems, including their supporting structures and vascular supply; the evaluation and treatment of pathological processes which modify function or activity of the nervous system; and the operative and non-operative management of pain. A neurological surgeon treats patients with disorders of the nervous system; disorders of the brain, meninges, skull, and their blood supply, including the extracranial carotid and vertebral arteries; disorders of the pituitary gland; disorders of the spinal cord, meninges, and vertebral column, including those which may require treatment by spinal fusion or instrumentation; and disorders of the cranial and spinal nerves throughout their distribution.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Neurological Surgery, 2007. http://www.abns.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Neurological Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Neuromusculoskeletal Medicine & OMM

204D00000X Neuromusculoskeletal Medicine & OMM Physician

The Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine physician directs special attention to the neuromusculoskeletal system and its interaction with other body systems. Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine encompasses increased knowledge and understanding of osteopathic principles and practice and heightened technical skills of osteopathic manipulative medicine, and integrates each of these into the management of pediatric, adolescent, adult, and geriatric patients.

Source: American Osteopathic Association, 2017 [7/1/2017: added definition]

Additional Resources: American Osteopathic Board of Neuromusculoskeletal Medicine, 2017, http://www.osteopathic.org/certification

Effective Date 4/1/2003

Allopathic & Osteopathic Physicians

Neuromusculoskeletal Medicine, Sports Medicine

204C00000X Sports Medicine (Neuromusculoskeletal Medicine) Physician

A Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine physician trained to be responsible for the continuous care in the field of sports medicine encompasses increased knowledge and understanding of osteopathic principles and practice and heightened technical skills of osteopathic manipulative medicine and integrates each of these into the management of the individual engaged in physical exercise (sports) whether as an individual or in team participation.

Source: American Osteopathic Association
Additional Resources: AOA Osteopathic Board Certification in Neuromusculoskeletal Medicine; https://certification.osteopathic.org/sports-medicine/

Effective Date 4/1/2003 Last Modified Date 1/1/2023

Nuclear Medicine

207U00000X Nuclear Medicine Physician

A nuclear medicine specialist employs the properties of radioactive atoms and molecules in the diagnosis and treatment of disease and in research. Radiation detection and imaging instrument systems are used to detect disease as it changes the function and metabolism of normal cells, tissues and organs. A wide variety of diseases can be found in this way, usually before the structure of the organ involved by the disease can be seen to be abnormal by any other techniques. Early detection of coronary artery disease (including acute heart attack), early cancer detection and evaluation of the effect of tumor treatment, diagnosis of infection and inflammation anywhere in the body and early detection of blood clot in the lungs are all possible with these techniques. Unique forms of radioactive molecules can attack and kill cancer cells (e.g., lymphoma, thyroid cancer) or can relieve the severe pain of cancer that has spread to bone

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Nuclear Medicine, 2007. http://www.abnm.org/. A doctor of osteopathy was able to obtain a Certificate of Added Qualifications in the field of Nuclear Medicine. The Certificate is NO longer offered.

American Osteopathic Board of Nuclear Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Nuclear Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: In Vivo & In Vitro Nuclear Medicine

207UN0903X In Vivo & In Vitro Nuclear Medicine Physician

A nuclear medicine physician who specializes in in vivo and in vitro nuclear medicine.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added]
Additional Resources: A Certification of Added Qualifications (CAQ) was, but is no longer issued by the American Osteopathic Board of Nuclear Medicine.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Allopathic & Osteopathic Physicians

Nuclear Medicine

Specialization: Nuclear Cardiology

207UN0901X Nuclear Cardiology Physician

A nuclear medicine physician who specializes in nuclear cardiology.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A Certification of Added Qualifications (CAQ) was, but is no longer issued by the American Osteopathic Board of Nuclear Medicine.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Nuclear Imaging & Therapy

207UN0902X Nuclear Imaging & Therapy Physician

A nuclear medicine physician who specializes in nuclear imaging and therapy.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A Certification of Added Qualifications (CAQ) was, but is no longer issued by the American Osteopathic Board of Nuclear Medicine.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Obstetrics & Gynecology

207V00000X Obstetrics & Gynecology Physician

An obstetrician/gynecologist possesses special knowledge, skills and professional capability in the medical and surgical care of the female reproductive system and associated disorders. This physician serves as a consultant to other physicians and as a primary physician for women.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Obstetrics and Gynecology, 2007. http://www.abog.org/. American Osteopathic Board of Obstetrics and Gynecology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Obstetrics and Gynecology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Obstetrics and Gynecology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Complex Family Planning

207VC0300X Complex Family Planning Physician

A complex family planning physician specializes in the diagnosis and treatment of individuals with complex reproductive needs. These physicians are experts in abortion and contraception clinical care, research, education, and advocacy.

Source: National Uniform Claim Committee, 2021. Resources: Society of Family Planning, www.societyfp.org.

Effective Date 4/1/2022

Allopathic & Osteopathic Physicians

Obstetrics & Gynecology

Specialization: Critical Care Medicine

207VC0200X **Critical Care Medicine (Obstetrics & Gynecology) Physician**

An obstetrician/gynecologist, who specializes in critical care medicine diagnoses, treats and supports female patients with multiple organ dysfunction. This specialist may have administrative responsibilities for intensive care units and may also facilitate and coordinate patient care among the primary physician, the critical care staff and other specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Obstetrics and Gynecology, 2007. http://www.abog.org/. American Osteopathic Board of Obstetrics and Gynecology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Obstetrics and Gynecology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Obstetrics and Gynecology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Female Pelvic Medicine and Reconstructive Surgery

207VF0040X **Female Pelvic Medicine and Reconstructive Surgery (Obstetrics & Gynecology) Physician**

A subspecialist in Female Pelvic Medicine and Reconstructive Surgery is a physician in Urology or Obstetrics and Gynecology who, by virtue of education and training, is prepared to provide consultation and comprehensive management of women with complex benign pelvic conditions, lower urinary tract disorders, and pelvic floor dysfunction. Comprehensive management includes those diagnostic and therapeutic procedures necessary for the total care of the patient with these conditions and complications resulting from them.

Source: American Board of Medical Specialties, 2011. [1/1/2012: new] Resources: www.abms.org

Effective Date 4/1/2012

Allopathic & Osteopathic Physicians

Obstetrics & Gynecology

Specialization: Gynecologic Oncology

207VX0201X Gynecologic Oncology Physician

An obstetrician/gynecologist who provides consultation and comprehensive management of patients with gynecologic cancer, including those diagnostic and therapeutic procedures necessary for the total care of the patient with gynecologic cancer and resulting complications.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Obstetrics and Gynecology, 2007. http://www.abog.org/. American Osteopathic Board of Obstetrics and Gynecology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Obstetrics and Gynecology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Obstetrics and Gynecology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Gynecology

207VG0400X Gynecology Physician

A physician who specializes in diagnosis, treatment, and management of patients with gynecologic conditions.

Source: National Uniform Claim Committee

Effective Date 4/1/2003 Last Modified Date 1/1/2023

Specialization: Hospice and Palliative Medicine

207VH0002X Hospice and Palliative Medicine (Obstetrics & Gynecology) Physician

An obstetrician/gynecologist with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Allopathic & Osteopathic Physicians

Obstetrics & Gynecology

Specialization: Maternal & Fetal Medicine

207VM0101X Maternal & Fetal Medicine Physician

An obstetrician/gynecologist who cares for, or provides consultation on, patients with complications of pregnancy. This specialist has advanced knowledge of the obstetrical, medical and surgical complications of pregnancy and their effect on both the mother and the fetus. The specialist also possesses expertise in the most current diagnostic and treatment modalities used in the care of patients with complicated pregnancies.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Obstetrics and Gynecology, 2007. http://www.abog.org/. American Osteopathic Board of Obstetrics and Gynecology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Obstetrics and Gynecology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Obstetrics and Gynecology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Obesity Medicine

207VB0002X Obesity Medicine (Obstetrics & Gynecology) Physician

A physician who specializes in the treatment of obesity demonstrates competency in and a thorough understanding of the treatment of obesity and the genetic, biologic, environmental, social, and behavioral factors that contribute to obesity. The obesity medicine physician employs therapeutic interventions including diet, physical activity, behavioral change, and pharmacotherapy. The obesity medicine physician utilizes a comprehensive approach, and may include additional resources such as dietitians, exercise physiologists, mental health professionals and bariatric surgeons as indicated to achieve optimal results. Additionally, the obesity medicine physician maintains competency in providing pre- peri- and post-surgical care of bariatric surgery patients, promotes the prevention of obesity, and advocates for those who suffer from obesity.

Source: American Board of Obesity Medicine, www.abom.org [10/1/2007: new, 7/1/2015: title and definition modified] Additional Resource: American Society of Bariatric Physicians, www.asbp.org.

Effective Date 10/1/2007

Specialization: Obstetrics

207VX0000X Obstetrics Physician

A physician who specializes in diagnosis, treatment, and management of patients with obstetric conditions.

Source: National Uniform Claim Committee

Effective Date 4/1/2003 Last Modified Date 1/1/2023

Allopathic & Osteopathic Physicians

Obstetrics & Gynecology

Specialization: Reproductive Endocrinology

207VE0102X Reproductive Endocrinology Physician

An obstetrician/gynecologist who is capable of managing complex problems relating to reproductive endocrinology and infertility.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Obstetrics and Gynecology, 2007. http://www.abog.org/. American Osteopathic Board of Obstetrics and Gynecology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Obstetrics and Gynecology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Obstetrics and Gynecology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Ophthalmology

207W00000X Ophthalmology Physician

An ophthalmologist has the knowledge and professional skills needed to provide comprehensive eye and vision care. Ophthalmologists are medically trained to diagnose, monitor and medically or surgically treat all ocular and visual disorders. This includes problems affecting the eye and its component structures, the eyelids, the orbit and the visual pathways. In so doing, an ophthalmologist prescribes vision services, including glasses and contact lenses.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Ophthalmology, 2007. http://www.abop.org/. American Osteopathic Board of Ophthalmology and Otolaryngology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Ophthalmology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Ophthalmology and Otolaryngology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Cornea and External Diseases Specialist

207WX0120X Cornea and External Diseases Specialist Physician

An ophthalmologist who specializes in diseases of the cornea, sclera, eyelids, conjunctiva, and anterior segment of the eye.

Source: American Academy of Ophthalmology, www.aao.org [1/1/2018: new]

Effective Date 4/1/2018

Allopathic & Osteopathic Physicians

Ophthalmology

Specialization: Glaucoma Specialist

207WX0009X Glaucoma Specialist (Ophthalmology) Physician

An ophthalmologist who specializes in the treatment of glaucoma and other disorders related to increased intraocular pressure and optic nerve damage. This specialty involves the medical and surgical treatment of these conditions.

Source: American Academy of Ophthalmology, www.aao.org [1/1/2017: new] Additional Resources: Association of University Professors of Ophthalmology, www.aupo.org

Effective Date 4/1/2017

Specialization: Neuro-ophthalmology

207WX0109X Neuro-ophthalmology Physician

A neuro-ophthalmologist is a subspecialist of ophthalmology. This physician evaluates, treats, and studies disorders of the eye, orbit and nervous system having to do with interactions of the visual motor and visual sensory systems with the central nervous system. Neuro-ophthalmologists manage patients with complex and severe neuro-ophthalmological disorders.

Source: American Academy of Ophthalmology, www.aao.org [7/1/2017: new]

Additional Resources: Association of University Professors of Ophthalmology, www.aupo.org.

Effective Date 10/1/2017

Specialization: Ophthalmic Plastic and Reconstructive Surgery

207WX0200X Ophthalmic Plastic and Reconstructive Surgery Physician

A physician who specializes in oculofacial plastic and reconstructive surgery. This subspecialty combines orbital and periocular surgery with facial plastic surgery, and includes aesthetic and reconstructive surgery of the face, orbit, eyelid, and lacrimal system. Practitioners evaluate, diagnose and treat conditions involving the eyelids, brows, midface, orbits, lacrimal systems and surrounding and supporting structures of the face and neck.

Source: American Academy of Ophthalmology, 2015. www.aao.org [1/1/2016: new]

Effective Date 4/1/2016

Specialization: Pediatric Ophthalmology and Strabismus Specialist

207WX0110X Pediatric Ophthalmology and Strabismus Specialist Physician Physician

An ophthalmologist who specializes in pediatric ophthalmology and strabismus management. The subspecialty includes the medical and surgical management of eye disorders found in children. Some of the more common disorders include amblyopia, strabismus, refractive error, cataract and glaucoma. These disorders may be related to neurological and endocrinological diseases, trauma, or aging changes in the extraocular muscles requiring medical, optical and surgical management.

Source: American Academy of Ophthalmology, www.aao.org [7/1/2017: new]

Additional Resources: Association of University Professors of Ophthalmology, www.aupo.org.

Effective Date 10/1/2017

Allopathic & Osteopathic Physicians

Ophthalmology

Specialization: Retina Specialist

207WX0107X Retina Specialist (Ophthalmology) Physician

An ophthalmologist who specializes in the diagnosis and treatment of vitreoretinal diseases.

Source: American Society of Retina Specialists, www.asrs.org [1/1/2017: new]

Additional Resources: American Academy of Ophthalmology, www.aao.org. Macula Society, www.maculasociety.org. Retina Society, www.retinasociety.org. Association of University Professors of Ophthalmology, www.aupo.org.

Effective Date 4/1/2017

Specialization: Uveitis and Ocular Inflammatory Disease

207WX0108X Uveitis and Ocular Inflammatory Disease (Ophthalmology) Physician

An ophthalmologist who specializes in the treatment of intraocular inflammation, scleritis, keratitis and infectious disorders affecting the eye and inflammatory disorders of the adnexa and/or orbit.

Source: American Academy of Ophthalmology, www.aao.org [1/1/2017: new]

Additional Resources: Association of University Professors of Ophthalmology, www.aupo.org

Effective Date 4/1/2017

Oral & Maxillofacial Surgery

204E00000X Oral & Maxillofacial Surgery (D.M.D.)

Oral and maxillofacial surgeons are trained to recognize and treat a wide spectrum of diseases, injuries and defects in the head, neck, face, jaws and the hard and soft tissues of the oral and maxillofacial region. They are also trained to administer anesthesia, and provide care in an office setting. They are trained to treat problems such as the extraction of wisdom teeth, misaligned jaws, tumors and cysts of the jaw and mouth, and to perform dental implant surgery.

Source: American College of Surgeons, 2013. www.facs.org [7/1/2013: definition added, source added, additional resources added] Additional Resources: American Board of Oral and Maxillofacial Surgery and American Association of Oral and Maxillofacial Surgeons While this is generally considered a specialty of dentistry, physicians can also be board certified as oral and maxillofacial surgeons through the American Board of Oral and Maxillofacial Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2013

Allopathic & Osteopathic Physicians

Orthopaedic Surgery

207X00000X Orthopaedic Surgery Physician

An orthopaedic surgeon is trained in the preservation, investigation and restoration of the form and function of the extremities, spine and associated structures by medical, surgical and physical means. An orthopaedic surgeon is involved with the care of patients whose musculoskeletal problems include congenital deformities, trauma, infections, tumors, metabolic disturbances of the musculoskeletal system, deformities, injuries and degenerative diseases of the spine, hands, feet, knee, hip, shoulder and elbow in children and adults. An orthopaedic surgeon is also concerned with primary and secondary muscular problems and the effects of central or peripheral nervous system lesions of the musculoskeletal system.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Orthopaedic Surgery, 2007. http://www.abos.org/. American Osteopathic Board of Orthopaedic Surgery, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Orthopaedic Surgery. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Orthopaedic Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Adult Reconstructive Orthopaedic Surgery

207XS0114X Adult Reconstructive Orthopaedic Surgery Physician

Recognized by several state medical boards as a fellowship subspecialty program of orthopaedic surgery, adult reconstructive orthopaedic surgeons deal with reconstructive procedures such as joint arthroplasty (i.e., hip and knee), osteotomy, arthroscopy, soft-tissue reconstruction, and a variety of other adult reconstructive surgical procedures.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Orthopaedic Surgery, 2007. http://www.abos.org/. Separate board certification is not currently offered.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Foot and Ankle Surgery

207XX0004X Orthopaedic Foot and Ankle Surgery Physician

Recognized by several state medical boards as a fellowship subspecialty program of orthopaedic surgery, foot and ankle surgeons deal with adult reconstructive foot and ankle surgery, adult foot and ankle trauma, sports medicine foot and ankle, and children's foot and ankle reconstructive surgery.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: title modified, definition added, source added] Additional Resources: American Board of Orthopaedic Surgery, 2007. http://www.abos.org/. Separate board certification is not currently offered. ACGME Accredited Residency Program Requirements: 1 year of training with 5 years Orthopedic Surgery for a total of 6 years.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Orthopaedic Surgery

Specialization: Hand Surgery

207XS0106X Orthopaedic Hand Surgery Physician

An orthopaedic surgeon trained in the investigation, preservation and restoration by medical, surgical and rehabilitative means of all structures of the upper extremity directly affecting the form and function of the hand and wrist.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Orthopaedic Surgery, 2007. http://www.abos.org/. American Osteopathic Board of Orthopaedic Surgery, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Orthopaedic Surgery. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Orthopaedic Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Orthopaedic Surgery of the Spine

207XS0117X Orthopaedic Surgery of the Spine Physician

Recognized by several state medical boards as a fellowship subspecialty program of orthopaedic surgery, orthopaedic surgeons of the spine deal with the evaluation and nonoperative and operative treatment of the full spectrum of primary spinal disorders including trauma, degenerative, deformity, tumor, and reconstructive.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Orthopaedic Surgery, 2007. http://www.abos.org/. Separate board certification is not currently offered.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Orthopaedic Trauma

207XX0801X Orthopaedic Trauma Physician

Recognized by several state medical boards as a fellowship subspecialty program of orthopaedic surgery, orthopaedic trauma surgeons deal with the evaluation and management of acute orthopaedic injuries, evaluation and treatment of post-traumatic deformities and nonunions, acute and delayed reconstruction of pelvic and acetabular fractures, as well as osteotomy in the adult hip for treatment of hip arthritis.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Orthopaedic Surgery, 2007. http://www.abos.org/. Separate board certification is not currently offered.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Orthopaedic Surgery

Specialization: Pediatric Orthopaedic Surgery

207XP3100X Pediatric Orthopaedic Surgery Physician

An orthopedic surgeon who has additional training and experience in diagnosing, treating and managing musculoskeletal problems in infants, children and adolescents. These may include limb and spine deformities (such as club foot, scoliosis); gait abnormalities (limping); bone and joint infections; broken bones.

Source: American Academy of Pediatrics, www.aap.org [7/1/2006: new]

Effective Date 10/1/2006

Specialization: Sports Medicine

207XX0005X Sports Medicine (Orthopaedic Surgery) Physician

An orthopaedic surgeon trained in sports medicine provides appropriate care for all structures of the musculoskeletal system directly affected by participation in sporting activity. This specialist is proficient in areas including conditioning, training and fitness, athletic performance and the impact of dietary supplements, pharmaceuticals, and nutrition on performance and health, coordination of care within the team setting utilizing other health care professionals, field evaluation and management, soft tissue biomechanics and injury healing and repair. Knowledge and understanding of the principles and techniques of rehabilitation, athletic equipment and orthotic devices enables the specialist to prevent and manage athletic injuries.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source changed] Additional Resources: American Board of Orthopaedic Surgery, 2007. http://www.abos.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Orthopaedic Surgery. ACGME Accredited Program Requirements: 1 year GME in the specialty + 5 years of Orthopaedic Surgery for a total of 6 years

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Otolaryngology

207Y00000X Otolaryngology Physician

An otolaryngologist-head and neck surgeon provides comprehensive medical and surgical care for patients with diseases and disorders that affect the ears, nose, throat, the respiratory and upper alimentary systems and related structures of the head and neck. An otolaryngologist diagnoses and provides medical and/or surgical therapy or prevention of diseases, allergies, neoplasms, deformities, disorders and/or injuries of the ears, nose, sinuses, throat, respiratory and upper alimentary systems, face, jaws and the other head and neck systems. Head and neck oncology, facial plastic and reconstructive surgery and the treatment of disorders of hearing and voice are fundamental areas of expertise.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Otolaryngology, 2007. http://www.aboto.org/. American Osteopathic Board of Ophthalmology and Otolaryngology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Otolaryngology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Ophthalmology and Otolaryngology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Facial Plastic Surgery

207YS0123X Facial Plastic Surgery Physician

An otolaryngologist who specializes in facial plastic surgery.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A General Certificate was, but is no longer issued by the American Osteopathic Board of Ophthalmology and Otolaryngology.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Otolaryngic Allergy

207YX0602X Otolaryngic Allergy Physician

An otolaryngologist who specializes in the diagnosis and treatment of otolaryngic allergies and other allergic diseases.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A Certification of Added Qualifications (CAQ) is issued by the American Osteopathic Board of Ophthalmology and Otolaryngology.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Allopathic & Osteopathic Physicians

Otolaryngology

Specialization: Otolaryngology/Facial Plastic Surgery

207YX0905X Otolaryngology/Facial Plastic Surgery Physician

An otolaryngologist who specializes in the diagnosis and surgical treatment of head and neck conditions.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A General Certificate is issued by the American Osteopathic Board of Ophthalmology and Otolaryngology.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Otology & Neurotology

207YX0901X Otology & Neurotology Physician

An otolaryngologist who treats diseases of the ear and temporal bone, including disorders of hearing and balance. The additional training in otology and neurotology emphasizes the study of embryology, anatomy, physiology, epidemiology, pathophysiology, pathology, genetics, immunology, microbiology and the etiology of diseases of the ear and temporal bone.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Otolaryngology, 2007. http://www.aboto.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Otolaryngology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Pediatric Otolaryngology

207YP0228X Pediatric Otolaryngology Physician

A pediatric otolaryngologist has special expertise in the management of infants and children with disorders that include congenital and acquired conditions involving the aerodigestive tract, nose and paranasal sinuses, the ear and other areas of the head and neck. The pediatric otolaryngologist has special skills in the diagnosis, treatment, and management of childhood disorders of voice, speech, language and hearing.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Otolaryngology, 2007. http://www.aboto.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Otolaryngology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Otolaryngology

Specialization: Plastic Surgery within the Head & Neck

207YX0007X Plastic Surgery within the Head & Neck (Otolaryngology) Physician

An otolaryngologist with additional training in plastic and reconstructive procedures within the head, face, neck and associated structures, including cutaneous head and neck oncology and reconstruction, management of maxillofacial trauma, soft tissue repair and neural surgery. The field is diverse and involves a wide age range of patients, from the newborn to the aged. While both cosmetic and reconstructive surgeries are practiced, there are many additional procedures which interface with them.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Otolaryngology, 2007. http://www.aboto.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Otolaryngology. Board certification for Doctors of Osteopathy is currently provided in the subspecialty of Otolaryngology/Facial Plastic Surgery (see Taxonomy Code 207YX0905X)

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Sleep Medicine

207YS0012X Sleep Medicine (Otolaryngology) Physician

An Otolaryngologist who practices Sleep Medicine is certified in the subspecialty of sleep medicine and specializes in the clinical assessment, physiologic testing, diagnosis, management and prevention of sleep and circadian rhythm disorders. Sleep specialists treat patients of any age and use multidisciplinary approaches. Disorders managed by sleep specialists include, but are not limited to, sleep related breathing disorders, insomnia, hypersomnias, circadian rhythm sleep disorders, parasomnias and sleep related movement disorders.

Source: American Academy of Sleep Medicine, www.aasm.org [7/1/2006: new]

Effective Date 10/1/2006

Pain Medicine

Specialization: Interventional Pain Medicine

208VP0014X Interventional Pain Medicine Physician

Interventional Pain Medicine is the discipline of medicine devoted to the diagnosis and treatment of pain and related disorders principally with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatment.

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Effective Date 4/1/2003

Allopathic & Osteopathic Physicians

Pain Medicine

Specialization: Pain Medicine

208VP0000X Pain Medicine Physician

Pain Medicine is a primary medical specialty based on a distinct body of knowledge and a well-defined scope of clinical practice that is founded on science, research and education. It is concerned with the study of pain, the prevention of pain, and the evaluation, treatment, and rehabilitation of persons in pain. A comprehensive evaluation incorporates the physical, psychological, cognitive and socio-cultural contributions to pain. The treatment protocol may include pharmacological, invasive, behavioral, cognitive, rehabilitative and complementary strategies provided in a concurrent focused and patient specific manner. The pain medicine physician often serves the patient as a frontline physician regarding their pain, but also may serve as a consultant to other physicians, direct an interdisciplinary/multidisciplinary treatment team, conduct research, or advocate for the patient's pain care with public and private agencies. The Pain Medicine physician may work in variety of settings including office, clinic, hospital, university, or governmental/public agencies.

Source: American Academy of Pain Medicine, www.painmed.org

Additional Resources: The American Board of Pain Medicine provides Board Certification.

Effective Date 4/1/2003

Pathology

Specialization: Anatomic Pathology

207ZP0101X Anatomic Pathology Physician

A pathologist deals with the causes and nature of disease and contributes to diagnosis, prognosis and treatment through knowledge gained by the laboratory application of the biologic, chemical and physical sciences. A pathologist uses information gathered from the microscopic examination of tissue specimens, cells and body fluids, and from clinical laboratory tests on body fluids and secretions for the diagnosis, exclusion and monitoring of disease.

Source: American Board of Medical Specialties, 2007. [7/1/2007: definition added, source added, 7/1/2009: definition reformatted; 7/1/2011: modified source]

Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. American Osteopathic Board of Pathology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology (note: this taxonomy code identifies the "anatomic pathology only" route). To acknowledge the diverse activities in the practice of pathology and to accommodate the interests of individuals wanting to enter the field, the ABP offers primary certification through the following three routes: combined anatomic pathology and clinical pathology, anatomic pathology only and clinical pathology only. Primary certification in anatomic pathology or clinical pathology may be combined with some of the subspecialty certifications.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Pathology

Specialization: Anatomic Pathology & Clinical Pathology

207ZP0102X Anatomic Pathology & Clinical Pathology Physician

A pathologist deals with the causes and nature of disease and contributes to diagnosis, prognosis and treatment through knowledge gained by the laboratory application of the biologic, chemical and physical sciences. A pathologist uses information gathered from the microscopic examination of tissue specimens, cells and body fluids, and from clinical laboratory tests on body fluids and secretions for the diagnosis, exclusion and monitoring of disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added, 7/1/2009: definition reformatted] Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/ This taxonomy code identifies the combined anatomic pathology & clinical pathology route. Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. To acknowledge the diverse activities in the practice of pathology and to accommodate the interests of individuals wanting to enter the field, the ABP offers primary certification through the following three routes: combined anatomic pathology and clinical pathology, anatomic pathology only and clinical pathology only. Primary certification in anatomic pathology or clinical pathology may be combined with some of the subspecialty certifications.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Blood Banking & Transfusion Medicine

207ZB0001X Blood Banking & Transfusion Medicine Physician

A physician who specializes in blood banking/transfusion medicine is responsible for the maintenance of an adequate blood supply, blood donor and patient-recipient safety and appropriate blood utilization. Pre-transfusion compatibility testing and antibody testing assure that blood transfusions, when indicated, are as safe as possible. This physician directs the preparation and safe use of specially prepared blood components, including red blood cells, white blood cells, platelets and plasma constituents, and marrow or stem cells for transplantation.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. American Osteopathic Board of Pathology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pathology. The Certification is NO longer provided.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Pathology

Specialization: Chemical Pathology

207ZP0104X Chemical Pathology Physician

A chemical pathologist has expertise in the biochemistry of the human body as it applies to the understanding of the cause and progress of disease. This physician functions as a clinical consultant in the diagnosis and treatment of human disease. Chemical pathology entails the application of biochemical data to the detection, confirmation or monitoring of disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. American Osteopathic Board of Pathology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pathology. The Certification is NO longer provided.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Clinical Informatics

207ZC0008X Clinical Informatics (Pathology) Physician

Physicians who practice Clinical Informatics collaborate with other health care and information technology professionals to analyze, design, implement and evaluate information and communication systems that enhance individual and population health outcomes, improve patient care, and strengthen the clinician-patient relationship. Clinical Informaticians use their knowledge of patient care combined with their understanding of informatics concepts, methods, and tools to: assess information and knowledge needs of health care professionals and patients; characterize, evaluate, and refine clinical processes; develop, implement, and refine clinical decision support systems; and lead or participate in the procurement, customization, development, implementation, management, evaluation, and continuous improvement of clinical information systems.

Source: The American Board of Preventive Medicine, 2013. www.theabpm.org [1/1/2014: new]
Additional Resources: The American Board of Pathology, www.abpath.org

Effective Date 4/1/2014

Allopathic & Osteopathic Physicians

Pathology

Specialization: Clinical Pathology

207ZC0006X Clinical Pathology Physician

A pathologist deals with the causes and nature of disease and contributes to diagnosis, prognosis and treatment through knowledge gained by the laboratory application of the biologic, chemical and physical sciences. A pathologist uses information gathered from the microscopic examination of tissue specimens, cells and body fluids, and from clinical laboratory tests on body fluids and secretions for the diagnosis, exclusion and monitoring of disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: new, 7/1/2009: definition reformatted] Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/ This taxonomy code identifies the combined anatomic "clinical pathology only" route. Board Certification for Medical Doctors (MDs) is provided by the American Board of Pathology. To acknowledge the diverse activities in the practice of pathology and to accommodate the interests of individuals wanting to enter the field, the ABP offers primary certification through the following three routes: combined anatomic pathology and clinical pathology, anatomic pathology only and clinical pathology only. Primary certification in anatomic pathology or clinical pathology may be combined with some of the subspecialty certifications.

Effective Date 10/1/2007

Specialization: Clinical Pathology/Laboratory Medicine

207ZP0105X Clinical Pathology/Laboratory Medicine Physician

A pathologist deals with the causes and nature of disease and contributes to diagnosis, prognosis and treatment through knowledge gained by the laboratory application of the biologic, chemical and physical sciences. A pathologist uses information gathered from the microscopic examination of tissue specimens, cells and body fluids, and from clinical laboratory tests on body fluids and secretions for the diagnosis, exclusion and monitoring of disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. American Osteopathic Board of Pathology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Pathology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Pathology

Specialization: Cytopathology

207ZC0500X Cytopathology Physician

A cytopathologist is an anatomic pathologist trained in the diagnosis of human disease by means of the study of cells obtained from body secretions and fluids, by scraping, washing, or sponging the surface of a lesion, or by the aspiration of a tumor mass or body organ with a fine needle. A major aspect of a cytopathologist's practice is the interpretation of Papanicolaou-stained smears of cells from the female reproductive systems, the "Pap" test. However, the cytopathologist's expertise is applied to the diagnosis of cells from all systems and areas of the body. He/she is a consultant to all medical specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source added] Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Dermatopathology

207ZD0900X Dermatopathology (Pathology) Physician

A dermatopathologist is an expert in diagnosing and monitoring diseases of the skin including infectious, immunologic, degenerative, and neoplastic diseases. This entails the examination and interpretation of specially prepared tissue sections, cellular scrapings, and smears of skin lesions by means of light microscopy, electron microscopy, and fluorescence microscopy.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source added] Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. A subspecialty certificate was first issued by the ABMS in 1974. ACGME Accredited Residency Program Requirements: None.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Forensic Pathology

207ZF0201X Forensic Pathology Physician

A forensic pathologist is expert in investigating and evaluating cases of sudden, unexpected, suspicious and violent death as well as other specific classes of death defined by law. The forensic pathologist serves the public as coroner or medical examiner, or by performing medicolegal autopsies for such officials.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. American Osteopathic Board of Pathology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Pathology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Pathology

Specialization: Hematology

207ZH0000X Hematology (Pathology) Physician

A hematopathologist is expert in diseases that affect blood cells, blood clotting mechanisms, bone marrow and lymph nodes. This physician has the knowledge and technical skills essential for the laboratory diagnosis of anemias, leukemias, lymphomas, bleeding disorders and blood clotting disorders.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. American Osteopathic Board of Pathology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pathology. The Certification is NO longer provided.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Immunopathology

207ZI0100X Immunopathology Physician

A pathologist who specializes in the diagnosis of immunologic diseases.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added]
Additional Resources: A Certification of Added Qualifications (CAQ) was, but is no longer issued by the American Osteopathic Board of Pathology.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Medical Microbiology

207ZM0300X Medical Microbiology Physician

A medical microbiologist is expert in the isolation and identification of microbial agents that cause infectious disease. Viruses, bacteria and fungi, as well as parasites, are identified and, where possible, tested for susceptibility to appropriate antimicrobial agents.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. American Osteopathic Board of Pathology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pathology. The Certification is NO longer provided.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Pathology

Specialization: Molecular Genetic Pathology

207ZP0007X Molecular Genetic Pathology (Pathology) Physician

A molecular genetic pathologist is expert in the principles, theory and technologies of molecular biology and molecular genetics. This expertise is used to make or confirm diagnoses of Mendelian genetic disorders, disorders of human development, infectious diseases and malignancies, and to assess the natural history of those disorders. A molecular genetic pathologist provides information about gene structure, function and alteration and applies laboratory techniques for diagnosis, treatment and prognosis for individuals with related disorders.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source changed] Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. A subspecialty certificate for MGG was approved by the ABMS in 1999. ACGME Accredited Residency Program Requirements: Proposal under development.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Neuropathology

207ZN0500X Neuropathology Physician

A neuropathologist is expert in the diagnosis of diseases of the nervous system and skeletal muscles and functions as a consultant primarily to neurologists and neurosurgeons. The neuropathologist is knowledgeable in the infirmities of humans as they affect the nervous and neuromuscular systems, be they degenerative, infectious, metabolic, immunologic, neoplastic, vascular or physical in nature.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. American Osteopathic Board of Pathology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pathology. The Certification is NO longer provided.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Pediatric Pathology

207ZP0213X Pediatric Pathology Physician

A pediatric pathologist is expert in the laboratory diagnosis of diseases that occur during fetal growth, infancy and child development. The practice requires a strong foundation in general pathology and substantial understanding of normal growth and development, along with extensive knowledge of pediatric medicine.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Pathology, 2007. http://www.abpath.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pathology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Pediatrics

208000000X Pediatrics Physician

A pediatrician is concerned with the physical, emotional and social health of children from birth to young adulthood. Care encompasses a broad spectrum of health services ranging from preventive healthcare to the diagnosis and treatment of acute and chronic diseases. A pediatrician deals with biological, social and environmental influences on the developing child, and with the impact of disease and dysfunction on development.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certificatio

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Adolescent Medicine

2080A0000X Pediatric Adolescent Medicine Physician

A pediatrician who specializes in adolescent medicine is a multi-disciplinary healthcare specialist trained in the unique physical, psychological and social characteristics of adolescents, their healthcare problems and needs.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Child Abuse Pediatrics

2080C0008X Child Abuse Pediatrics Physician

A Child Abuse Pediatrician serves as a resource to children, families and communities by accurately diagnosing abuse; consulting with community agencies on child safety; providing expertise in courts of law; treating consequences of abuse and neglect; directing child abuse and neglect prevention programs and participating on multidisciplinary teams investigating; and managing child abuse cases.

Source: American Board of Medical Specialties, 2009 [7/1/2009: new]

Effective Date 10/1/2009

Allopathic & Osteopathic Physicians

Pediatrics

Specialization: Clinical & Laboratory Immunology

2080I0007X Pediatric Clinical & Laboratory Immunology Physician

A pediatrician who specializes in clinical and laboratory immunology disease management.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A certification was, but is no longer issued by the American Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Developmental - Behavioral Pediatrics

2080P0006X Developmental - Behavioral Pediatrics Physician

A developmental-behavioral specialist is a pediatrician with special training and experience who aims to foster understanding and promotion of optimal development of children and families through research, education, clinical care and advocacy efforts. This physician assists in the prevention, diagnosis, and management of developmental difficulties and problematic behaviors in children and in the family dysfunctions that compromise children's development.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source changed, 3/26/2008: definition corrected] Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Hospice and Palliative Medicine

2080H0002X Pediatric Hospice and Palliative Medicine Physician

A pediatrician with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Allopathic & Osteopathic Physicians

Pediatrics

Specialization: Medical Toxicology

2080T0002X Pediatric Medical Toxicology Physician

Medical toxicologists are physicians that specialize in the prevention, evaluation, treatment and monitoring of injury and illness from exposures to drugs and chemicals, as well as biological and radiological agents. Medical toxicologists care for people in clinical, academic, governmental and public health settings, and provide poison control center leadership. Important areas of medical toxicology include acute drug poisoning, adverse drug events, drug abuse, addiction and withdrawal, chemicals and hazardous materials, terrorism preparedness, venomous bites and stings, and environmental and workplace exposures.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source added] Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. ACGME Accredited Residency Program Requirements: Medical Toxicology (EM) 2 years with 3-4 years Emergency Medicine for a total of 5-6 years; for Medical Toxicology (Preventive Medicine) 2 years with 3 years Preventive Medicine for a total of 5 years. Medical Toxicology (Pediatrics): None. ABMS Approved Subspecialty Certificates (Emergency Medicine) (Pediatrics) (Preventive Medicine)

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Neonatal-Perinatal Medicine

2080N0001X Neonatal-Perinatal Medicine Physician

A pediatrician who is the principal care provider for sick newborn infants. Clinical expertise is used for direct patient care and for consulting with obstetrical colleagues to plan for the care of mothers who have high-risk pregnancies.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Neurodevelopmental Disabilities

2080P0008X Pediatric Neurodevelopmental Disabilities Physician

A pediatrician who specializes in the treatment of individuals with developmental delays and learning disorders associated with cerebral palsy, spina bifida, autism, and other chronic neurologic conditions.

Source: National Uniform Claim Committee, www.nucc.org

Effective Date 4/1/2003 Last Modified Date 7/1/2022

Allopathic & Osteopathic Physicians

Pediatrics

Specialization: Obesity Medicine

2080B0002X Pediatric Obesity Medicine Physician

A physician who specializes in the treatment of obesity demonstrates competency in and a thorough understanding of the treatment of obesity and the genetic, biologic, environmental, social, and behavioral factors that contribute to obesity. The obesity medicine physician employs therapeutic interventions including diet, physical activity, behavioral change, and pharmacotherapy. The obesity medicine physician utilizes a comprehensive approach, and may include additional resources such as dietitians, exercise physiologists, mental health professionals and bariatric surgeons as indicated to achieve optimal results. Additionally, the obesity medicine physician maintains competency in providing pre- peri- and post-surgical care of bariatric surgery patients, promotes the prevention of obesity, and advocates for those who suffer from obesity.

Source: American Board of Obesity Medicine, www.abom.org [7/1/2015: new] Additional Resource: American Society of Bariatric Physicians, www.asbp.org.

Effective Date 10/1/2015

Specialization: Pediatric Allergy/Immunology

2080P0201X Pediatric Allergy/Immunology Physician

A pediatrician who specializes in the diagnosis and treatment of allergies, allergic reactions, and immunologic diseases in children.

Source: National Uniform Claim Committee, 2009 [1/1/2010: title modified, definition added, source added] Additional Resources: A Certification of Special Qualifications (CSQ) is issued by the American Osteopathic Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Pediatric Cardiology

2080P0202X Pediatric Cardiology Physician

A pediatric cardiologist provides comprehensive care to patients with cardiovascular problems. This specialist is skilled in selecting, performing and evaluating the structural and functional assessment of the heart and blood vessels, and the clinical evaluation of cardiovascular disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pediatrics. The Certification is no longer offered.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Pediatrics

Specialization: Pediatric Critical Care Medicine

2080P0203X Pediatric Critical Care Medicine Physician

A pediatrician expert in advanced life support for children from the term or near-term neonate to the adolescent. This competence extends to the critical care management of life-threatening organ system failure from any cause in both medical and surgical patients and to the support of vital physiological functions. This specialist may have administrative responsibilities for intensive care units and also facilitates patient care among other specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source added] Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. ACGME Accredited Residency Program Requirements: 2 years of training with 3 years Pediatrics plus 1 year Pediatric Critical Care for certification for a total of 6 years. ABMS Approved Subspecialty Certificate (Pediatrics)

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Pediatric Emergency Medicine

2080P0204X Pediatric Emergency Medicine (Pediatrics) Physician

A pediatrician who has special qualifications to manage emergencies in infants and children.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Pediatric Endocrinology

2080P0205X Pediatric Endocrinology Physician

A pediatrician who provides expert care to infants, children and adolescents who have diseases that result from an abnormality in the endocrine glands (glands which secrete hormones). These diseases include diabetes mellitus, growth failure, unusual size for age, early or late pubertal development, birth defects, the genital region and disorders of the thyroid, the adrenal and pituitary glands.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Pediatrics

Specialization: Pediatric Gastroenterology

2080P0206X Pediatric Gastroenterology Physician

A pediatrician who specializes in the diagnosis and treatment of diseases of the digestive systems of infants, children and adolescents. This specialist treats conditions such as abdominal pain, ulcers, diarrhea, cancer and jaundice and performs complex diagnostic and therapeutic procedures using lighted scopes to see internal organs.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Pediatric Hematology-Oncology

2080P0207X Pediatric Hematology & Oncology Physician

A pediatrician trained in the combination of pediatrics, hematology and oncology to recognize and manage pediatric blood disorders and cancerous diseases.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pediatrics. The Certification is no longer offered.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Pediatric Infectious Diseases

2080P0208X Pediatric Infectious Diseases Physician

A pediatrician trained to care for children in the diagnosis, treatment and prevention of infectious diseases. This specialist can apply specific knowledge to affect a better outcome for pediatric infections with complicated courses, underlying diseases that predispose to unusual or severe infections, unclear diagnoses, uncommon diseases and complex or investigational treatments.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pediatrics. The Certification is no longer offered.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Pediatrics

Specialization: Pediatric Nephrology

2080P0210X Pediatric Nephrology Physician

A pediatrician who deals with the normal and abnormal development and maturation of the kidney and urinary tract, the mechanisms by which the kidney can be damaged, the evaluation and treatment of renal diseases, fluid and electrolyte abnormalities, hypertension and renal replacement therapy.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pediatrics. The Certification is no longer offered.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Pediatric Pulmonology

2080P0214X Pediatric Pulmonology Physician

A pediatrician dedicated to the prevention and treatment of all respiratory diseases affecting infants, children and young adults. This specialist is knowledgeable about the growth and development of the lung, assessment of respiratory function in infants and children, and experienced in a variety of invasive and noninvasive diagnostic techniques.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) was provided by the American Osteopathic Board of Pediatrics. The Certification is no longer offered.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Pediatric Rheumatology

2080P0216X Pediatric Rheumatology Physician

A pediatrician who treats diseases of joints, muscle, bones and tendons. A pediatric rheumatologist diagnoses and treats arthritis, back pain, muscle strains, common athletic injuries and "collagen" diseases.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Pediatrics

Specialization: Pediatric Transplant Hepatology

2080T0004X Pediatric Transplant Hepatology Physician

A pediatrician with expertise in transplant hepatology encompasses the special knowledge and skill required of pediatric gastroenterologists to care for patients prior to and following hepatic transplantation; it spans all phases of liver transplantation.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: new] Additional Resources; American Board of Pediatrics, 2007. http://www.abp.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics.

Effective Date 10/1/2007

Specialization: Sleep Medicine

2080S0012X Pediatric Sleep Medicine Physician

A Pediatrician who practices Sleep Medicine is certified in the subspecialty of sleep medicine and specializes in the clinical assessment, physiologic testing, diagnosis, management and prevention of sleep and circadian rhythm disorders. Sleep specialists treat patients of any age and use multidisciplinary approaches. Disorders managed by sleep specialists include, but are not limited to, sleep related breathing disorders, insomnia, hypersomnias, circadian rhythm sleep disorders, parasomnias and sleep related movement disorders.

Source: American Academy of Sleep Medicine, www.aasm.org [7/1/2006: new]

Effective Date 10/1/2006

Specialization: Sports Medicine

2080S0010X Pediatric Sports Medicine Physician

A pediatrician who is responsible for continuous care in the field of sports medicine, not only for the enhancement of health and fitness, but also for the prevention of injury and illness. A sports medicine physician must have knowledge and experience in the promotion of wellness and the prevention of injury. Knowledge about special areas of medicine such as exercise physiology, biomechanics, nutrition, psychology, physical rehabilitation, epidemiology, physical evaluation, injuries (treatment and prevention and referral practice) and the role of exercise in promoting a healthy lifestyle are essential to the practice of sports medicine. The sports medicine physician requires special education to provide the knowledge to improve the healthcare of the individual engaged in physical exercise (sports) whether as an individual or in team participation.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Pediatrics, 2007. http://www.abp.org/. American Osteopathic Board of Pediatrics, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Pediatrics. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Pediatrics.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Phlebology

202K00000X Phlebology Physician

Phlebology is the medical discipline that involves the diagnosis and treatment of venous disorders, including spider veins, varicose veins, chronic venous insufficiency, venous leg ulcers, congenital venous abnormalities, venous thromboembolism and other disorders of venous origin. A phlebologist has attained a minimum of 50 hours of CME units in phlebology-related courses, and is knowledgeable of and trained in a variety of diagnostic techniques including physical examination, venous imaging techniques such as duplex ultrasound, CT and MR, plethysmographic techniques and laboratory evaluation related to venous thromboembolism. The phlebologist is also trained in a variety of therapeutic interventions, which may include compression, sclerotherapy, cutaneous vascular laser, endovenous thermoablation procedures (laser and radiofrequency) endovenous chemical ablation, surgical procedures (e.g., ambulatory phlebectomy, venous ligation), vasoactive medications and the management of venous thromboembolism.

Source: American College of Phlebology 12/2006. www.phelbology.org [1/1/2007: new, 7/1/2009: definition reformatted] Additional Resources: Training Programs, Fellowships, and/or Preceptorships: Certification exam is being established by the American Board of Phlebology. ACGME Accredited Residency Program Requirements: None

Effective Date 4/1/2007

Physical Medicine & Rehabilitation

208100000X Physical Medicine & Rehabilitation Physician

Physical medicine and rehabilitation, also referred to as rehabilitation medicine, is the medical specialty concerned with diagnosing, evaluating, and treating patients with physical disabilities. These disabilities may arise from conditions affecting the musculoskeletal system such as neck and back pain, sports injuries, or other painful conditions affecting the limbs, such as carpal tunnel syndrome. Alternatively, the disabilities may result from neurological trauma or disease such as spinal cord injury, head injury or stroke. A physician certified in physical medicine and rehabilitation is often called a physiatrist. The primary goal of the physiatrist is to achieve maximal restoration of physical, psychological, social and vocational function through comprehensive rehabilitation. Pain management is often an important part of the role of the physiatrist. For diagnosis and evaluation, a physiatrist may include the techniques of electromyography to supplement the standard history, physical, x-ray and laboratory examinations. The physiatrist has expertise in the appropriate use of therapeutic exercise, prosthetics (artificial limbs), orthotics and mechanical and electrical devices.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Physical Medicine and Rehabilitation, 2007. http://www.abpmr.org/. American Osteopathic Board of Physical Medicine and Rehabilitation, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Physical Medicine and Rehabilitation. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Physical Medicine and Rehabilitation.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Physical Medicine & Rehabilitation

Specialization: Brain Injury Medicine

2081P0301X Brain Injury Medicine (Physical Medicine & Rehabilitation) Physician

A Brain Injury Medicine physician specializes in disorders of brain function due to injury and disease. These disorders encompass a range of medical, physical, neurologic, cognitive, sensory, and behavioral disorders that result in psychosocial, educational, and vocational consequences.

Source: American Board of Physical Medicine and Rehabilitation, 2015. www.abpmr.org [1/1/2016: new]

Effective Date 4/1/2016

Specialization: Hospice and Palliative Medicine

2081H0002X Hospice and Palliative Medicine (Physical Medicine & Rehabilitation) Physician

A physical medicine and rehabilitation physician with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Specialization: Neuromuscular Medicine

2081N0008X Neuromuscular Medicine (Physical Medicine & Rehabilitation) Physician

A physician who specializes in neuromuscular medicine possesses specialized knowledge in the science, clinical evaluation and management of these disorders. This encompasses the knowledge of the pathology, diagnosis and treatment of these disorders at a level that is significantly beyond the training and knowledge expected of a general neurologist, child neurologist or physiatrist.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: new] Additional Resources: American Board of Physical Medicine and Rehabilitation, 2007. http://www.abpmr.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Physical Medicine and Rehabilitation.

Effective Date 10/1/2007

Allopathic & Osteopathic Physicians

Physical Medicine & Rehabilitation

Specialization: Pain Medicine

2081P2900X Pain Medicine (Physical Medicine & Rehabilitation) Physician

A physician who provides a high level of care, either as a primary physician or consultant, for patients experiencing problems with acute, chronic or cancer pain in both hospital and ambulatory settings. Patient care needs may also be coordinated with other specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source changed] Additional Resources: American Board of Physical Medicine and Rehabilitation, 2007. http://www.abpmr.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Physical Medicine and Rehabilitation. A subspecialty certificate was approved by the ABMS in 1999. ACGME Accredited Residency Program Requirements: Proposal under development.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Pediatric Rehabilitation Medicine

2081P0010X Pediatric Rehabilitation Medicine Physician

A physiatrist who utilizes an interdisciplinary approach and addresses the prevention, diagnosis, treatment and management of congenital and childhood-onset physical impairments including related or secondary medical, physical, functional, psychosocial and vocational limitations or conditions, with an understanding of the life course of disability. This physician is trained in the identification of functional capabilities and selection of the best of rehabilitation intervention strategies, with an understanding of the continuum of care.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source added] Additional Resources: American Board of Physical Medicine and Rehabilitation, 2007. http://www.abpmr.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Physical Medicine and Rehabilitation. A subspecialty certificate for PRM was approved by the ABMS in 1999. ACGME Accredited Residency Program Requirements: Early discussions underway

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Spinal Cord Injury Medicine

2081P0004X Spinal Cord Injury Medicine Physician

A physician who addresses the prevention, diagnosis, treatment and management of traumatic spinal cord injury and non-traumatic etiologies of spinal cord dysfunction by working in an interdisciplinary manner. Care is provided to patients of all ages on a lifelong basis and covers related medical, physical, psychological and vocational disabilities and complications.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source added] Additional Resources: American Board of Physical Medicine and Rehabilitation, 2007. http://www.abpmr.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Physical Medicine and Rehabilitation. ACGME Accredited Residency Program Requirements: 1 year of training with 3-5 years in relevant specialty for a total of 4-6 years. ABMS Approved Subspecialty Certificate: (Physical Medicine and Rehabilitation)

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Physical Medicine & Rehabilitation

Specialization: Sports Medicine

2081S0010X Sports Medicine (Physical Medicine & Rehabilitation) Physician

A physician who specializes in Sports Medicine is responsible for continuous care related to the enhancement of health and fitness as well as the prevention of injury and illness. The specialist possesses knowledge and experience in the promotion of wellness and the prevention of injury from many areas of medicine such as exercise physiology, biomechanics, nutrition, psychology, physical rehabilitation, epidemiology, physical evaluation and injuries. It is the goal of a Sports Medicine specialist to improve the healthcare of the individual engaged in physical exercise.

Source: American Board of Medical Specialties, 2009. www.abms.org [7/1/2009: definition added]

Effective Date 4/1/2003

Plastic Surgery

208200000X Plastic Surgery Physician

A plastic surgeon deals with the repair, reconstruction or replacement of physical defects of form or function involving the skin, musculoskeletal system, craniomaxillofacial structures, hand, extremities, breast and trunk and external genitalia or cosmetic enhancement of these areas of the body. Cosmetic surgery is an essential component of plastic surgery. The plastic surgeon uses cosmetic surgical principles to both improve overall appearance and to optimize the outcome of reconstructive procedures. The surgeon uses aesthetic surgical principles not only to improve undesirable qualities of normal structures but in all reconstructive procedures as well.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Plastic Surgery, 2007. http://www.abplsurg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Plastic Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Plastic Surgery Within the Head and Neck

2082S0099X Plastic Surgery Within the Head and Neck (Plastic Surgery) Physician

A plastic surgeon with additional training in plastic and reconstructive procedures within the head, face, neck and associated structures, including cutaneous head and neck oncology and reconstruction, management of maxillofacial trauma, soft tissue repair and neural surgery. The field is diverse and involves a wide age range of patients, from the newborn to the aged. While both cosmetic and reconstructive surgery is practiced, there are many additional procedures which interface with them.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source added] Additional Resources: American Board of Plastic Surgery, 2007. http://www.abplsurg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Plastic Surgery. A subspecialty certificate was approved by the ABMS in 2000. ACGME Accredited Residency Program Requirements: None.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Plastic Surgery

Specialization: Surgery of the Hand

2082S0105X Surgery of the Hand (Plastic Surgery) Physician

A plastic surgeon with additional training in the investigation, preservation, and restoration by medical, surgical and rehabilitative means of all structures of the upper extremity directly affecting the form and function of the hand and wrist.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Plastic Surgery, 2007. http://www.abplsurg.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Plastic Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Preventive Medicine

Specialization: Addiction Medicine

2083A0300X Addiction Medicine (Preventive Medicine) Physician

A physician engaged in the subspecialty practice of Addiction Medicine who specializes in the prevention, evaluation, diagnosis, treatment, and recovery of persons with the disease of addiction.

Source: American Board of Preventive Medicine, www.theabpm.org [1/1/2019: new]

Effective Date 4/1/2019

Specialization: Aerospace Medicine

2083A0100X Aerospace Medicine Physician

Aerospace medicine focuses on the clinical care, research, and operational support of the health, safety, and performance of crewmembers and passengers of air and space vehicles, together with the support personnel who assist operation of such vehicles. This population often works and lives in remote, isolated, extreme, or enclosed environments under conditions of physical and psychological stress. Practitioners strive for an optimal human-machine match in occupational settings rich with environmental hazards and engineering countermeasures.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Preventive Medicine, 2007. http://www.abprevmed.org/. American Osteopathic Board of Preventive Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Preventive Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Preventive Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Preventive Medicine

Specialization: Clinical Informatics

2083C0008X Clinical Informatics Physician

Physicians who practice Clinical Informatics collaborate with other health care and information technology professionals to analyze, design, implement and evaluate information and communication systems that enhance individual and population health outcomes, improve patient care, and strengthen the clinician-patient relationship. Clinical Informaticians use their knowledge of patient care combined with their understanding of informatics concepts, methods, and tools to: assess information and knowledge needs of health care professionals and patients; characterize, evaluate, and refine clinical processes; develop, implement, and refine clinical decision support systems; and lead or participate in the procurement, customization, development, implementation, management, evaluation, and continuous improvement of clinical information systems.

Source: The American Board of Preventive Medicine, 2013 [1/1/2014: new] Additional Resources: The American Board of Preventive Medicine, www.theabpm.org

Effective Date 4/1/2014

Specialization: Medical Toxicology

2083T0002X Medical Toxicology (Preventive Medicine) Physician

Medical toxicologists are physicians who specialize in the prevention, evaluation, treatment and monitoring of injury and illness from exposures to drugs and chemicals, as well as biological and radiological agents. Medical toxicologists care for people in clinical, academic, governmental and public health settings, and provide poison control center leadership. Important areas of medical toxicology include acute drug poisoning, adverse drug events, drug abuse, addiction and withdrawal, chemicals and hazardous materials, terrorism preparedness, venomous bites and stings, and environmental and workplace exposures.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Preventive Medicine, 2007. http://www.abprevmed.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Preventive Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Obesity Medicine

2083B0002X Obesity Medicine (Preventive Medicine) Physician

A physician who specializes in the treatment of obesity demonstrates competency in and a thorough understanding of the treatment of obesity and the genetic, biologic, environmental, social, and behavioral factors that contribute to obesity. The obesity medicine physician employs therapeutic interventions including diet, physical activity, behavioral change, and pharmacotherapy. The obesity medicine physician utilizes a comprehensive approach, and may include additional resources such as dietitians, exercise physiologists, mental health professionals and bariatric surgeons as indicated to achieve optimal results. Additionally, the obesity medicine physician maintains competency in providing pre- peri- and post-surgical care of bariatric surgery patients, promotes the prevention of obesity, and advocates for those who suffer from obesity.

Source: American Board of Obesity Medicine, www.abom.org [7/1/2015: new] Additional Resource: American Society of Bariatric Physicians, www.asbp.org.

Effective Date 10/1/2015

Allopathic & Osteopathic Physicians

Preventive Medicine

Specialization: Occupational Medicine

2083X0100X Occupational Medicine Physician

Occupational medicine focuses on the health of workers, including the ability to perform work; the physical, chemical, biological, and social environments of the workplace; and the health outcomes of environmental exposures. Practitioners in this field address the promotion of health in the work place, and the prevention and management of occupational and environmental injury, illness, and disability.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Preventive Medicine, 2007. http://www.abprevmed.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Preventive Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Preventive Medicine/Occupational Environmental Medicine

2083P0500X Preventive Medicine/Occupational Environmental Medicine Physician

A preventive medicine physician who specializes in preventive medicine/occupational-environmental medicine, which is focused on protecting the population from occupational and environmental conditions.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A General Certificate is issued by the American Osteopathic Board of Preventive Medicine.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Public Health & General Preventive Medicine

2083P0901X Public Health & General Preventive Medicine Physician

Public health and general preventive medicine focuses on promoting health, preventing disease, and managing the health of communities and defined populations. These practitioners combine population-based public health skills with knowledge of primary, secondary, and tertiary prevention-oriented clinical practice in a wide variety of settings.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Preventive Medicine, 2007. http://www.abprevmed.org/. American Osteopathic Board of Preventive Medicine, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Preventive Medicine. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Preventive Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Preventive Medicine

Specialization: Sports Medicine

2083S0010X Sports Medicine (Preventive Medicine) Physician

A preventive medicine physician who specializes in the diagnosis and treatment of sports related conditions and injuries.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A Certification of Added Qualifications (CAQ) is issued by the American Osteopathic Board of Preventive Medicine.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Undersea and Hyperbaric Medicine

2083P0011X Undersea and Hyperbaric Medicine (Preventive Medicine) Physician

A specialist who treats decompression illness and diving accident cases and uses hyperbaric oxygen therapy to treat such conditions as carbon monoxide poisoning, gas gangrene, non-healing wounds, tissue damage from radiation and burns and bone infections. This specialist also serves as consultant to other physicians in all aspects of hyperbaric chamber operations and assesses risks and applies appropriate standards to prevent disease and disability in divers and other persons working in altered atmospheric conditions.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Preventive Medicine, 2007. http://www.abprevmed.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Preventive Medicine.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Psychiatry & Neurology

Specialization: Addiction Medicine

2084A0401X Addiction Medicine (Psychiatry & Neurology) Physician

A doctor of osteopathy board eligible/certified in the field of Psychiatry by the American Osteopathic Board of Neurology and Psychiatry is able to obtain a Certificate of Added Qualifications in the field of Addiction Medicine

Source: American Osteopathic Board of Neurology and Psychiatry, 2007 [1/1/2008: definition added, source added; 7/1/2011: modified source]

Additional Resources: http://www.osteopathic.org/certification

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Addiction Psychiatry

2084P0802X Addiction Psychiatry Physician

Addiction Psychiatry is a subspecialty of psychiatry that focuses on evaluation and treatment of individuals with alcohol, drug, or other substance-related disorders, and of individuals with dual diagnosis of substance-related and other psychiatric disorders.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Allopathic & Osteopathic Physicians

Psychiatry & Neurology

Specialization: Behavioral Neurology & Neuropsychiatry

2084B0040X Behavioral Neurology & Neuropsychiatry Physician

Behavioral Neurology & Neuropsychiatry is a medical subspecialty involving the diagnosis and treatment of neurologically based behavioral issues.

Source: National Uniform Claim Committee. [1/1/2012: new] Additional Resources: American Academy of Neurology, www.aan.com.

Effective Date 4/1/2012

Specialization: Brain Injury Medicine

2084P0301X Brain Injury Medicine (Psychiatry & Neurology) Physician

A Brain Injury Medicine physician specializes in disorders of brain function due to injury and disease. These disorders encompass a range of medical, physical, neurologic, cognitive, sensory, and behavioral disorders that result in psychosocial, educational, and vocational consequences.

Source: American Board of Physical Medicine and Rehabilitation, 2015. www.abpmr.org [1/1/2016: new]

Effective Date 4/1/2016

Specialization: Child & Adolescent Psychiatry

2084P0804X Child & Adolescent Psychiatry Physician

Child & Adolescent Psychiatry is a subspecialty of psychiatry with additional skills and training in the diagnosis and treatment of developmental, behavioral, emotional, and mental disorders of childhood and adolescence.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Specialization: Clinical Neurophysiology

2084N0600X Clinical Neurophysiology Physician

Clinical Neurophysiology is a subspecialty with psychiatric or neurologic expertise in the diagnosis and management of central, peripheral, and autonomic nervous system disorders using combined clinical evaluation and electrophysiologic testing such as electroencephalography (EEG), electromyography (EMG), and nerve conduction studies (NCS).

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Allopathic & Osteopathic Physicians

Psychiatry & Neurology

Specialization: Diagnostic Neuroimaging

2084D0003X Diagnostic Neuroimaging (Psychiatry & Neurology) Physician

A licensed physician, who has completed a residency program in Neurology, and who has additional training, experience, and competence in the standards of performance and interpretation of Magnetic Resonance Imaging (MRI / MRA) of the head, spine, and peripheral nerves, and Computed Tomography (CT) of the head and spine. Physicians are trained in the administration of contrast media and the recognition and treatment of adverse reactions to contrast media. Neuroimaging training encompasses thorough knowledge of clinical neurology, neurophysiology, neuroanatomy, neurochemistry, neuropharmacology, and dynamics of cerebrospinal fluid circulation. Physicians possess special expertise in the technical aspects and clinical applications of each of the modalities and techniques of neuroimaging.

Source: American Academy of Neurology, www.aan.com [1/1/2007: new]

Effective Date 4/1/2007

Specialization: Epilepsy

2084E0001X Epilepsy Physician

Epilepsy is a subspecialty of neurology focused on the diagnosis and treatment of patients with epilepsy, including new-onset, medically refractory epilepsy, psychogenic nonepileptic seizures, and epilepsy in special populations (the elderly, women, patients with co-morbidities). Epilepsy is a multidisciplinary field that provides comprehensive care of the patient.

Source: American Epilepsy Society, www.aesnet.org [7/1/2021: new]

Effective Date 10/1/2021 Last Modified Date 7/1/2021

Specialization: Forensic Psychiatry

2084F0202X Forensic Psychiatry Physician

Forensic Psychiatry is a subspecialty with psychiatric focus on interrelationships with civil, criminal and administrative law, evaluation and specialized treatment of individuals involved with the legal system, incarcerated in jails, prisons, and forensic psychiatry hospitals.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Specialization: Geriatric Psychiatry

2084P0805X Geriatric Psychiatry Physician

Geriatric Psychiatry is a subspecialty with psychiatric expertise in prevention, evaluation, diagnosis and treatment of mental and emotional disorders in the elderly, and improvement of psychiatric care for healthy and ill elderly patients.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Allopathic & Osteopathic Physicians

Psychiatry & Neurology

Specialization: Hospice and Palliative Medicine

2084H0002X Hospice and Palliative Medicine (Psychiatry & Neurology) Physician

A psychiatrist or neurologist with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Specialization: Neurocritical Care

2084A2900X Neurocritical Care Physician

The medical subspecialty of Neurocritical Care is devoted to the comprehensive, multisystem care of the critically-ill neurological patient. Like other intensivists, the neurointensivist generally assumes the primary role for coordinating the care of his or her patients in the ICU, both the neurological and medical management of the patient. They may also provide consultative services for these patients as requested within the health system.

Source: Adapted from the United Council for Neurologic Subspecialties website definition at: http://www.ucns.org/go/subspecialty/neurocritical [7/1/2016: new]

Effective Date 10/1/2016

Specialization: Neurodevelopmental Disabilities

2084P0005X Neurodevelopmental Disabilities Physician

A neurologist who specializes in the treatment of individuals with developmental delays and learning disorders associated with cerebral palsy, spina bifida, autism, and other chronic neurologic conditions.

Source: National Uniform Claim Committee, www.nucc.org

Effective Date 4/1/2003 Last Modified Date 7/1/2022

Specialization: Neurology

2084N0400X Neurology Physician

A Neurologist specializes in the diagnosis and treatment of diseases or impaired function of the brain, spinal cord, peripheral nerves, muscles, autonomic nervous system, and blood vessels that relate to these structures.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Allopathic & Osteopathic Physicians

Psychiatry & Neurology

Specialization: Neurology with Special Qualifications in Child Neurology

2084N0402X Neurology with Special Qualifications in Child Neurology Physician

A Child Neurologist specializes in neurology with special skills in diagnosis and treatment of neurologic disorders of the neonatal period, infancy, early childhood, and adolescence.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Specialization: Neuromuscular Medicine

2084N0008X Neuromuscular Medicine (Psychiatry & Neurology) Physician

A neurologist or child neurologist who specializes in the diagnosis and management of disorders of nerve, muscle or neuromuscular junction, including amyotrophic lateral sclerosis, peripheral neuropathies (e.g., diabetic and immune mediated neuropathies), various muscular dystrophies, congenital and acquired myopathies, inflammatory myopathies (e.g., polymyositis, inclusion body myositis) and neuromuscular transmission disorders (e.g., myasthenia gravis, Lambert-Eaton myasthenic syndrome).

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: new] Additional Resources: American Board of Psychiatry and Neurology, 2007. http://www.abpn.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Psychiatry and Neurology

Effective Date 10/1/2007

Specialization: Obesity Medicine

2084B0002X Obesity Medicine (Psychiatry & Neurology) Physician

A physician who specializes in the treatment of obesity demonstrates competency in and a thorough understanding of the treatment of obesity and the genetic, biologic, environmental, social, and behavioral factors that contribute to obesity. The obesity medicine physician employs therapeutic interventions including diet, physical activity, behavioral change, and pharmacotherapy. The obesity medicine physician utilizes a comprehensive approach, and may include additional resources such as dietitians, exercise physiologists, mental health professionals and bariatric surgeons as indicated to achieve optimal results. Additionally, the obesity medicine physician maintains competency in providing pre- peri- and post-surgical care of bariatric surgery patients, promotes the prevention of obesity, and advocates for those who suffer from obesity.

Source: American Board of Obesity Medicine, www.abom.org [10/1/2007: new, 7/1/2015: title and definition modified] Additional Resource: American Society of Bariatric Physicians, www.asbp.org.

Effective Date 10/1/2007

Allopathic & Osteopathic Physicians

Psychiatry & Neurology

Specialization: Pain Medicine

2084P2900X Pain Medicine (Psychiatry & Neurology) Physician

A neurologist, child neurologists or psychiatrist who provides a high level of care, either as a primary physician or consultant, for patients experiencing problems with acute, chronic or cancer pain in both hospital and ambulatory settings. Patient care needs may also be coordinated with other specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition changed, source added] Additional Resources: American Board of Psychiatry and Neurology, 2007. http://www.abpn.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Psychiatry and Neurology. A subspecialty certificate was approved by ABMS in 1998. ACGME Accredited Residency Program Requirements: None.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Psychiatry

2084P0800X Psychiatry Physician

A Psychiatrist specializes in the prevention, diagnosis, and treatment of mental disorders, emotional disorders, psychotic disorders, mood disorders, anxiety disorders, substance-related disorders, sexual and gender identity disorders and adjustment disorders. Biologic, psychological, and social components of illnesses are explored and understood in treatment of the whole person. Tools used may include diagnostic laboratory tests, prescribed medications, evaluation and treatment of psychological and interpersonal problems with individuals and families, and intervention for coping with stress, crises, and other problems.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Specialization: Psychosomatic Medicine

2084P0015X Psychosomatic Medicine Physician

Psychosomatic Medicine is subspecialty in the diagnosis and treatment of psychiatric disorders and symptoms in complex medically ill patients. This subspecialty includes treatment of patients with acute or chronic medical, neurological, obstetrical or surgical illness in which psychiatric illness is affecting their medical care and/or quality of life such as HIV infection, organ transplantation, heart disease, renal failure, cancer, stroke, traumatic brain injury, high-risk pregnancy and COPD, among others. Patients also may be those who have a psychiatric disorder that is the direct consequence of a primary medical condition, or a somatoform disorder or psychological factors affecting a general medical condition. Psychiatrists specializing in Psychosomatic Medicine provide consultation-liaison services in general medical hospitals, attend on medical psychiatry inpatient units, and provide collaborative care in primary care and other outpatient settings.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new]

Effective Date 4/1/2007

Allopathic & Osteopathic Physicians

Psychiatry & Neurology

Specialization: Sleep Medicine

2084S0012X Sleep Medicine (Psychiatry & Neurology) Physician

A Psychiatrist or Neurologist who practices Sleep Medicine is certified in the subspecialty of sleep medicine and specializes in the clinical assessment, physiologic testing, diagnosis, management and prevention of sleep and circadian rhythm disorders. Sleep specialists treat patients of any age and use multidisciplinary approaches. Disorders managed by sleep specialists include, but are not limited to, sleep related breathing disorders, insomnia, hypersomnias, circadian rhythm sleep disorders, parasomnias and sleep related movement disorders.

Source: American Academy of Sleep Medicine, www.aasm.org [7/1/2006: new]

Effective Date 10/1/2006

Specialization: Sports Medicine

2084S0010X Sports Medicine (Psychiatry & Neurology) Physician

A psychiatrist or neurologist who specializes in the diagnosis and treatment of sports related conditions and injuries.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added]
Additional Resources: A Certification of Added Qualifications (CAQ) was, but is no longer issued by the American Osteopathic Board of Neurology and Psychiatry.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Vascular Neurology

2084V0102X Vascular Neurology Physician

Vascular Neurology is a subspecialty in the evaluation, prevention, treatment and recovery from vascular diseases of the nervous system. This subspecialty includes the diagnosis and treatment of vascular events of arterial or venous origin from a large number of causes that affect the brain or spinal cord such as ischemic stroke, intracranial hemorrhage, spinal cord ischemia and spinal cord hemorrhage.

Source: The American Board of Psychiatry and Neurology, Inc. www.abpn.com [1/1/2007: new definition]

Effective Date 4/1/2003 Last Modified Date 1/1/2007

Radiology

Specialization: Body Imaging

2085B0100X Body Imaging Physician

A Radiology doctor of Osteopathy that specializes in Body Imaging.

Source: National Uniform Claim Committee, 2008 [7/1/2008: definition added, source added]
Additional Resources: The American Osteopathic Board of Radiology no longer offers a certificate in this specialty.

Effective Date 4/1/2003

Allopathic & Osteopathic Physicians

Radiology

Specialization: Diagnostic Neuroimaging

2085D0003X Diagnostic Neuroimaging (Radiology) Physician

A licensed physician, who has completed a residency program in Neurology, and who has additional training, experience, and competence in the standards of performance and interpretation of Magnetic Resonance Imaging (MRI / MRA) of the head, spine, and peripheral nerves, and Computed Tomography (CT) of the head and spine. Physicians are trained in the administration of contrast media and the recognition and treatment of adverse reactions to contrast media. Neuroimaging training encompasses thorough knowledge of clinical neurology, neurophysiology, neuroanatomy, neurochemistry, neuropharmacology, and dynamics of cerebrospinal fluid circulation. Physicians possess special expertise in the technical aspects and clinical applications of each of the modalities and techniques of neuroimaging.

Source: American Academy of Neurology, www.aan.com [1/1/2007: new]

Effective Date 4/1/2007

Specialization: Diagnostic Radiology

2085R0202X Diagnostic Radiology Physician

A radiologist who utilizes x-ray, radionuclides, ultrasound and electromagnetic radiation to diagnose and treat disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Radiology, 2007. http://www.theabr.org/. American Osteopathic Board of Radiology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Radiology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Radiology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Diagnostic Ultrasound

2085U0001X Diagnostic Ultrasound Physician

A Radiology doctor of Osteopathy that specializes in Diagnostic Ultrasound.

Source: National Uniform Claim Committee, 2008 [7/1/2008: definition added, source added]
Additional Resources: The American Osteopathic Board of Radiology no longer offers a certificate in this specialty. [Note: In medical practice, Diagnostic Ultrasound is part of the scope of training and practice of a Diagnostic Radiologists - see Taxonomy Code 2085R0202X.]

Effective Date 4/1/2003

Allopathic & Osteopathic Physicians

Radiology

Specialization: Hospice and Palliative Medicine

2085H0002X Hospice and Palliative Medicine (Radiology) Physician

A radiologist with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Specialization: Neuroradiology

2085N0700X Neuroradiology Physician

A radiologist who diagnoses and treats diseases utilizing imaging procedures as they relate to the brain, spine and spinal cord, head, neck and organs of special sense in adults and children.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Radiology, 2007. http://www.theabr.org/. American Osteopathic Board of Radiology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Radiology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Radiology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Nuclear Radiology

2085N0904X Nuclear Radiology Physician

A radiologist who is involved in the analysis and imaging of radionuclides and radiolabeled substances in vitro and in vivo for diagnosis and the administration of radionuclides and radiolabeled substances for the treatment of disease.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Radiology, 2007. http://www.theabr.org/. American Osteopathic Board of Radiology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Radiology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Radiology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Radiology

Specialization: Pediatric Radiology

2085P0229X Pediatric Radiology Physician

A radiologist who is proficient in all forms of diagnostic imaging as it pertains to the treatment of diseases in the newborn, infant, child and adolescent. This specialist has knowledge of both imaging and interventional procedures related to the care and management of diseases of children. A pediatric radiologist must be highly knowledgeable of all organ systems as they relate to growth and development, congenital malformations, diseases peculiar to infants and children and diseases that begin in childhood but cause substantial residual impairment in adulthood.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Radiology, 2007. http://www.theabr.org/. American Osteopathic Board of Radiology, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Radiology. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Radiology.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Radiation Oncology

2085R0001X Radiation Oncology Physician

A radiologist who deals with the therapeutic applications of radiant energy and its modifiers and the study and management of disease, especially malignant tumors.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Osteopathic Board of Radiology, 2007. http://www.osteopathic.org/certification

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Radiological Physics

2085R0205X Radiological Physics Physician

A radiological physicist deals with the diagnostic and therapeutic applications of roentgen rays, gamma rays from sealed sources, ultrasonic radiation and radio-frequency radiation, as well as the equipment associated with their production and use, including radiation safety.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Radiology, 2007. http://www.theabr.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Radiology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Radiology

Specialization: Therapeutic Radiology

2085R0203X Therapeutic Radiology Physician

Definition to come...

#Type!

Effective Date 4/1/2003

Specialization: Vascular & Interventional Radiology

2085R0204X Vascular & Interventional Radiology Physician

A radiologist who diagnoses and treats diseases by various radiologic imaging modalities. These include fluoroscopy, digital radiography, computed tomography, sonography and magnetic resonance imaging.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Radiology, 2007. http://www.theabr.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Radiology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Surgery

208600000X Surgery Physician

A general surgeon has expertise related to the diagnosis - preoperative, operative and postoperative management - and management of complications of surgical conditions in the following areas: alimentary tract; abdomen; breast, skin and soft tissue; endocrine system; head and neck surgery; pediatric surgery; surgical critical care; surgical oncology; trauma and burns; and vascular surgery. General surgeons increasingly provide care through the use of minimally invasive and endoscopic techniques. Many general surgeons also possess expertise in transplantation surgery, plastic surgery and cardiothoracic surgery.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Surgery, 2007. http://www.absurgery.org/. American Osteopathic Board of Surgery, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Surgery. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Allopathic & Osteopathic Physicians

Surgery

Specialization: Hospice and Palliative Medicine

2086H0002X Hospice and Palliative Medicine (Surgery) Physician

A surgeon with special knowledge and skills to prevent and relieve the suffering experienced by patients with life-limiting illnesses. This specialist works with an interdisciplinary hospice or palliative care team to maximize quality of life while addressing physical, psychological, social and spiritual needs of both patient and family throughout the course of the disease, through the dying process, and beyond for the family. This specialist has expertise in the assessment of patients with advanced disease; the relief of distressing symptoms; the coordination of interdisciplinary patient and family-centered care in diverse venues; the use of specialized care systems including hospice; the management of the imminently dying patient; and legal and ethical decision making in end-of-life care.

Source: American Academy of Hospice and Palliative Medicine, www.aahpm.org [1/1/2007: new]

Effective Date 4/1/2007

Specialization: Pediatric Surgery

2086S0120X Pediatric Surgery Physician

A surgeon with expertise in the management of surgical conditions in premature and newborn infants, children and adolescents.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Surgery, 2007. http://www.absurgery.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Plastic and Reconstructive Surgery

2086S0122X Plastic and Reconstructive Surgery Physician

A surgeon who specializes in plastic and reconstructive surgery.

Source: National Uniform Claim Committee, 2009 [1/1/2010: definition added, source added] Additional Resources: A General Certificate is issued by the American Osteopathic Board of Surgery.

Effective Date 4/1/2003 Last Modified Date 1/1/2010

Specialization: Surgery of the Hand

2086S0105X Surgery of the Hand (Surgery) Physician

A surgeon with expertise in the investigation, preservation and restoration by medical, surgical and rehabilitative means, of all structures of the upper extremity directly affecting the form and function of the hand and wrist.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Surgery, 2007. http://www.absurgery.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Allopathic & Osteopathic Physicians

Surgery

Specialization: Surgical Critical Care

2086S0102X Surgical Critical Care Physician

A surgeon with expertise in the management of the critically ill and postoperative patient, particularly the trauma victim, who specializes in critical care medicine diagnoses, treats and supports patients with multiple organ dysfunction. This specialist may have administrative responsibilities for intensive care units and may also facilitate and coordinate patient care among the primary physician, the critical care staff and other specialists.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Surgery, 2007. http://www.absurgery.org/. American Osteopathic Board of Surgery, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Surgery. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Specialization: Surgical Oncology

2086X0206X Surgical Oncology Physician

A surgical oncologist is a well-qualified surgeon who has obtained additional training and experience in the multidisciplinary approach to the prevention, diagnosis, treatment, and rehabilitation of cancer patients, and devotes a major portion of his or her professional practice to these activities and cancer research.

Source: Society of Surgical Oncology, 2007 [1/1/2008: definition added, source added, 7/1/2009: definition reformatted] Additional Resources: http://www.surgonc.org/ ; American Board of Medical Specialties, 2007, www.abms.org ; American Board of Surgery, 2007, http://www.absurgery.org/ Surgical oncology is a recognized fellowship subspecialty program of surgery. Separate board certification is not currently offered.

Effective Date 4/1/2003 Last Modified Date 1/1/2008

Specialization: Trauma Surgery

2086S0127X Trauma Surgery Physician

Trauma surgery is a recognized subspecialty of general surgery. Trauma surgeons are physicians who have completed a five-year general surgery residency and usually continue with a one to two year fellowship in trauma and/or surgical critical care, typically leading to additional board certification in surgical critical care. There is no trauma surgery board certification at this point. To obtain board certification in surgical critical care, a fellowship in surgical critical care or anesthesiology critical care must be completed during or after general surgery residency.

Source: American Board of Surgery, 2007 [1/1/2008: definition added, source added] Additional Resources: http://www.absurgery.org/.

Effective Date 4/1/2003 Last Modified Date 1/1/2008

Allopathic & Osteopathic Physicians

Surgery

Specialization: Vascular Surgery

2086S0129X Vascular Surgery Physician

A surgeon with expertise in the management of surgical disorders of the blood vessels, excluding the intracranial vessels or the heart.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added; 7/1/2011: modified source]

Additional Resources: American Board of Surgery, 2007. http://www.absurgery.org/. American Osteopathic Board of Surgery, 2007. http://www.osteopathic.org/certification

Board certification for Medical Doctors (MDs) is provided by the American Board of Surgery. Board certification for Doctors of Osteopathy (DOs) is provided by the American Osteopathic Board of Surgery.

Effective Date 4/1/2003 Last Modified Date 7/1/2011

Thoracic Surgery (Cardiothoracic Vascular Surgery)

208G00000X Thoracic Surgery (Cardiothoracic Vascular Surgery) Physician

A thoracic surgeon provides the operative, perioperative and critical care of patients with pathologic conditions within the chest. Included is the surgical care of coronary artery disease, cancers of the lung, esophagus and chest wall, abnormalities of the trachea, abnormalities of the great vessels and heart valves, congenital anomalies, tumors of the mediastinum and diseases of the diaphragm. The management of the airway and injuries of the chest is within the scope of the specialty.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Thoracic Surgery, 2007. http://www.abts.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Thoracic Surgery. Thoracic surgeons have the knowledge, experience and technical skills to accurately diagnose, operate upon safely, and effectively manage patients with thoracic diseases of the chest. This requires substantial knowledge of cardiorespiratory physiology and oncology, as well as capability in the use of heart assist devices, management of abnormal heart rhythms and drainage of the chest cavity, respiratory support systems, endoscopy and invasive and noninvasive diagnostic techniques.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Transplant Surgery

204F00000X Transplant Surgery Physician

A surgeon who specializes in transplant surgery.

Source: National Uniform Claim Committee

Effective Date 4/1/2003 Last Modified Date 1/1/2023

Allopathic & Osteopathic Physicians

Urology

208800000X Urology Physician

A urologist manages benign and malignant medical and surgical disorders of the genitourinary system and the adrenal gland. This specialist has comprehensive knowledge of and skills in endoscopic, percutaneous and open surgery of congenital and acquired conditions of the urinary and reproductive systems and their contiguous structures.

Source: American Board of Medical Specialties, 2007. www.abms.org [7/1/2007: definition added, source added] Additional Resources: American Board of Urology, 2007. http://www.abu.org/. Board certification for Medical Doctors (MDs) is provided by the American Board of Urology.

Effective Date 4/1/2003 Last Modified Date 7/1/2007

Specialization: Female Pelvic Medicine and Reconstructive Surgery

2088F0040X Female Pelvic Medicine and Reconstructive Surgery (Urology) Physician

A subspecialist in Female Pelvic Medicine and Reconstructive Surgery is a physician in Urology or Obstetrics and Gynecology who, by virtue of education and training, is prepared to provide consultation and comprehensive management of women with complex benign pelvic conditions, lower urinary tract disorders, and pelvic floor dysfunction. Comprehensive management includes those diagnostic and therapeutic procedures necessary for the total care of the patient with these conditions and complications resulting from them.

Source: American Board of Medical Specialties, 2011. [1/1/2012: new] Resources: www.abms.org

Effective Date 4/1/2012

Specialization: Pediatric Urology

2088P0231X Pediatric Urology Physician

Surgeons who can diagnose, treat, and manage children's urinary and genital problems. A pediatric urologist devotes a minimum of 50% of his or her practice to the urologic problems of infants, children, and adolescents. Pediatric urologists generally provide the following services: the evaluation and management of voiding disorders; vesicoureteral reflux, and urinary tract infections that require surgery; surgical reconstruction of the urinary tract (kidneys, ureters, and bladder) including genital abnormalities, hypospadias, and intersex conditions; surgery for groin conditions in childhood and adolescence (undescended testes, hydrocele/hernia, varicocele).

Source: American Academy of Pediatrics [7/1/2006: new]

Effective Date 10/1/2006

Behavioral Health & Social Service Providers

Assistant Behavior Analyst

106E00000X Assistant Behavior Analyst

An assistant behavior analyst is qualified by Behavior Analyst Certification Board certification and/or a state-issued license or credential in behavior analysis to practice under the supervision of an appropriately credentialed professional behavior analyst. An assistant behavior analyst delivers services consistent with the dimensions of applied behavior analysis and supervision requirements defined in state laws or regulations and/or national certification standards. Common services may include, but are not limited to, conducting behavioral assessments, analyzing data, writing behavior-analytic treatment plans, training and supervising others in implementation of components of treatment plans, and direct implementation of treatment plans.

Association of Professional Behavior Analysts, www.apbahome.net and Behavior Analyst Certification Board (http://www.bacb.com) [7/1/2016: new]

Effective Date 10/1/2016

Behavior Analyst

103K00000X Behavioral Analyst

A behavior analyst is qualified by at least a master's degree and Behavior Analyst Certification Board certification and/or a state-issued credential (such as a license) to practice behavior analysis independently. Behavior analysts provide the required supervision to assistant behavior analysts and behavior technicians. A behavior analyst delivers services consistent with the dimensions of applied behavior analysis. Common services may include, but are not limited to, conducting behavioral assessments, analyzing data, writing and revising behavior-analytic treatment plans, training others to implement components of treatment plans, and overseeing implementation of treatment plans.

Source: Association of Professional Behavior Analysts, www.apbahome.net and Behavior Analyst Certification Board (http://www.bacb.com) [7/1/2008: new, 1/1/2016: modified definition]

Effective Date 10/1/2008 Last Modified Date 1/1/2016

Behavior Technician

106S00000X Behavior Technician

The behavior technician is a paraprofessional who practices under the close, ongoing supervision of a behavior analyst or assistant behavior analyst certified by the Behavior Analyst Certification Board and/or credentialed by a state (such as through licensure). The behavior technician is primarily responsible for the implementation of components of behavior-analytic treatment plans developed by the supervisor. That may include collecting data on treatment targets and conducting certain types of behavioral assessments (e.g., stimulus preference assessments). The behavior technician does not design treatment or assessment plans or procedures but provides services as assigned by the supervisor responsible for his or her work.

Association of Professional Behavior Analysts, www.apbahome.net and Behavior Analyst Certification Board (http://www.bacb.com) [7/1/2016: new]

Effective Date 10/1/2016

Behavioral Health & Social Service Providers

Clinical Neuropsychologist

103G00000X Clinical Neuropsychologist

A clinical psychologist who applies principles of assessment and intervention based upon the scientific study of human behavior as it relates to normal and abnormal functioning of the central nervous system. The specialty is dedicated to enhancing the understanding of brain-behavior relationships and the application of such knowledge to human problems.

Source: American Psychological Association, www.apa.org [1/1/2007: title modified, 1/1/2019: definition modified]

Effective Date 4/1/2002 Last Modified Date 1/1/2007

Specialization: Clinical

103GC0700X Deactivated - Clinical Neuropsychologist

[1/1/2007: marked inactive, use 103G00000X]

Effective Date 4/1/2002 Last Modified Date 1/1/2007 Deactivation Date 3/31/2007

Counselor

101Y00000X Counselor

A provider who is trained and educated in the performance of behavior health services through interpersonal communications and analysis. Training and education at the specialty level usually requires a master's degree and clinical experience and supervision for licensure or certification.

Sources: Abridged from definitions provided by the National Board of Certified Counselors and the American Association of Pastoral Counselors.

Effective Date 4/1/2002

Specialization: Addiction (Substance Use Disorder)

101YA0400X Addiction (Substance Use Disorder) Counselor

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Mental Health

101YM0800X Mental Health Counselor

Definition to come...

#Type!

Effective Date 4/1/2002

Behavioral Health & Social Service Providers

Counselor

Specialization: Pastoral

101YP1600X **Pastoral Counselor**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Professional

101YP2500X **Professional Counselor**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: School

101YS0200X **School Counselor**

Definition to come...

#Type!

Effective Date 4/1/2002

Drama Therapist

101200000X **Drama Therapist**

Drama therapists are trained in the intentional use of drama and theatre processes to achieve therapeutic goals. Drama therapists provide psychotherapy for individuals living with mental health and behavioral concerns that may result in psychological suffering, impaired relationships, or distress in daily activities. Drama therapy promotes wellness and healing within the context of a therapeutic relationship for individuals of varying ability levels across the lifespan. Drama therapy can take many forms depending on individual and group needs, skill and ability levels, interests, and therapeutic goals. Processes and techniques may include improvisation, theater games, storytelling, and enactment.

Source: North American Drama Therapy Association, www.nadta.org [1/1/2021: new]

Effective Date 4/1/2021

Marriage & Family Therapist

106H00000X **Marriage & Family Therapist**

A marriage and family therapist is a person with a master's degree in marriage and family therapy, or a master's or doctoral degree in a related mental health field with substantially equivalent coursework in marriage and family therapy, who receives supervised clinical experience, or a person who meets the state requirements to practice as a marriage and family therapist. A marriage and family therapist treats mental and emotional disorders within the context of marriage and family systems. A marriage and family therapist provides mental health and counseling services to individuals, couples, families, and groups.

#Type!

Effective Date 4/1/2002

Behavioral Health & Social Service Providers

Poetry Therapist

102X00000X Poetry Therapist

A medical or mental health professional who has attained credentials after satisfactorily completing a poetry therapy training program approved by the National Federation for Biblio/Poetry Therapy (NFBPT). Training includes didactic work, peer group experience, and supervised practicum.

An NFBPT credentialed certified poetry therapist (CPT) or registered poetry therapist (PTR) integrates discussion of published literature and reflective or creative writing into the psychotherapeutic process to achieve goals of emotional well-being, symptom reduction, and improved interpersonal communication.

Certified poetry therapists and registered poetry therapists are licensed mental health professionals with advanced training in the theory and practice of poetry therapy. CPTs and PTRs are qualified to work independently with emotionally troubled populations in clinical, rehabilitative, community and educational institutions. They also work with emotionally healthy individuals adjusting to developmental issues, life crises, or disabilities. The PTR completes an advanced level of training and fieldwork, commensurate with the highest levels of clinical practice. The terms poetry therapy, applied poetry facilitation, journal therapy, bibliotherapy, biblio/poetry therapy, and poetry/journal therapy reflect the interactive use of literature and/or writing to promote personal growth and emotional healing. In addition to poetry, poetry therapy applies all forms or written and spoken language including story, myth, folk and fairy tale and other genres of poetic expression as well as journal, memoir, and narrative. The poetry therapy process integrates discussion of published literature and reflective or creative writing for expression and communication of thoughts and feelings to facilitate participants' emotional well-being. The field of poetry therapy encompasses all of these modalities, though only a duly trained and licensed clinical practitioner can be credentialed as CPT or PTR.

Source: The National Federation for Biblio/Poetry Therapy [7/1/2007: new]

Effective Date 10/1/2007

Psychoanalyst

102L00000X Psychoanalyst

Psychoanalysis is a comprehensive, theoretical framework which, when applied to a treatment process, consists of an intensive verbal, therapeutic relationship between an analyst and an analysand which aims for symptom relief, emotional growth, and personal integration. The psychoanalytic treatment process includes, but is not limited to, the recognition of unconscious processes and conflicts; the significance of developmental influences; and the impact of resistances, defenses, transference and countertransference phenomena. Treatment is enhanced by an understanding developed in the analyst's training and personal analysis of unconscious manifestations, such as dreams, slips of the tongue, fantasies and day dreams. Psychoanalytic technique varies in relation to theoretical orientation.

Source: Registry of Psychoanalysts published by the National Association for the Advancement of Psychoanalysis [1/1/2007: new; 7/1/2007: definition changed, source changed]

Effective Date 4/1/2007 Last Modified Date 7/1/2007

Behavioral Health & Social Service Providers

Psychologist

103T00000X Psychologist

A psychologist is an individual who is licensed to practice psychology which is defined as the observation, description, evaluation, interpretation, and modification of human behavior by the application of psychological principles, methods, and procedures, for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior and of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health, and mental health. The practice of psychology includes, but is not limited to, psychological testing and the evaluation or assessment of personal characteristics, such as intelligence, personality, abilities, interests, aptitudes, and neuropsychological functioning; counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, and behavior analysis and therapy; diagnosis and treatment of mental and emotional disorder or disability, alcoholism and substance abuse, disorders of habit or conduct, as well as of the psychological aspects of physical illness, accident, injury, or disability; and psycheducational evaluation, therapy, remediation, and consultation. Psychological services may be rendered to individuals, families, groups and the public.

Source: American Psychological Association [1/1/2007: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2007

Specialization: Addiction (Substance Use Disorder)

103TA0400X Addiction (Substance Use Disorder) Psychologist

A psychologist with a proficiency that involves the application of psychological treatment of addiction stemming from the use of alcohol and other psychoactive substances (e.g., nicotine, marijuana, cocaine, heroin) or behavioral addictions (e.g., gambling) with the aim of cessation or reduction of use and/or the amelioration of emotional, behavioral, interpersonal and other problems arising from the addictive behavior.

Source: American Psychological Association, www.apa.org [1/1/2019: new definition]

Additional Resources: The APA proficiency is Addiction Psychology.

Effective Date 4/1/2002

Specialization: Adult Development & Aging

103TA0700X Adult Development & Aging Psychologist

A psychologist who specializes in geropsychology, which applies the knowledge and methods of psychology to understanding and helping older persons and their families to maintain well-being, overcome problems and achieve maximum potential during later life. Professional geropsychology appreciates the wide diversity among older adults, the complex ethical issues that can arise in geriatric practice and the importance of interdisciplinary models of care.

Source: American Psychological Association, www.apa.org [1/1/2019: new definition]

Additional Resources: The APA specialty is "Geropsychology."

Effective Date 4/1/2002

Behavioral Health & Social Service Providers

Psychologist

Specialization: Clinical

103TC0700X **Clinical Psychologist**

A psychologist who provides continuing and comprehensive mental and behavioral health care for individuals and families; consultation to agencies and communities; training, education and supervision; and research-based practice. It is a specialty in breadth -- one that is broadly inclusive of severe psychopathology -- and marked by comprehensiveness and integration of knowledge and skill from a broad array of disciplines within and outside of psychology proper. The scope of clinical psychology encompasses all ages, multiple diversities and varied systems.

Source: American Psychological Association, www.apa.org [1/1/2019: new definition]

Effective Date 4/1/2002

Specialization: Clinical Child & Adolescent

103TC2200X **Clinical Child & Adolescent Psychologist**

A psychologist who develops and applies scientific knowledge to the delivery of psychological services to infants, toddlers, children and adolescents within their social context. Of particular importance to the specialty of clinical child psychology is an understanding of the basic psychological needs of children and adolescents, and how the family and other social contexts influence the socio-emotional adjustment, cognitive development, behavioral adaptation and health status of children and adolescents.

Source: American Psychological Association, www.apa.org [1/1/2007: title modified, 1/1/2019: new definition]

Additional Resources: The APA specialty is "Clinical Child Psychology."

Effective Date 4/1/2002 Last Modified Date 1/1/2007

Specialization: Cognitive & Behavioral

103TB0200X **Cognitive & Behavioral Psychologist**

A psychologist who reflects an experimental-clinical approach distinguished by use of principles of human learning and development and theories of cognitive processing to promote meaningful change in maladaptive human behavior and thinking.

Source: American Psychological Association, www.apa.org [1/1/2007: title modified, 1/1/2019: new definition]

Additional Resources: The APA specialty is "Behavioral and Cognitive Psychology."

Effective Date 4/1/2002 Last Modified Date 1/1/2007

Behavioral Health & Social Service Providers

Psychologist

Specialization: Counseling

103TC1900X Counseling Psychologist

A psychologist who specializes in general practice and health service. It focuses on how people function both personally and in their relationships at all ages. Counseling psychology addresses the emotional, social, work, school and physical health concerns people may have at different stages in their lives, focusing on typical life stresses and more severe issues with which people may struggle as individuals and as a part of families, groups and organizations. Counseling psychologists help people with physical, emotional and mental health issues improve their sense of well-being, alleviate feelings of distress and resolve crises. They also provide assessment, diagnosis, and treatment of more severe psychological symptoms.

Source: American Psychological Association, www.apa.org [1/1/2019: new definition]

Effective Date 4/1/2002

Specialization: Educational

103TE1000X Deactivated - Psychologist

[1/1/2007: marked inactive]

Effective Date 4/1/2002 Deactivation Date 3/31/2007

Specialization: Exercise & Sports

103TE1100X Exercise & Sports Psychologist

A psychologist with a proficiency in sports psychology that uses psychological knowledge and skills to address optimal performance and well-being of athletes, developmental and social aspects of sports participation, and systemic issues associated with sports settings and organizations. APA recognizes sport psychology as a proficiency acquired after a doctoral degree in one of the primary areas of psychology and licensure as a psychologist. This proficiency does not include those who have earned a doctoral degree in sport psychology but are not licensed psychologists.Sport Psychology interventions are designed to assist athletes and other sports participants (e.g., coaches, administrators, parents) from a wide array of settings, levels of competition, and ages, ranging from recreational youth participants to professional and Olympic athletes to master's level performers.

Source: American Psychological Association, www.apa.org [1/1/2019: new definition]

Additional Resources: The APA proficiency is "Sport Psychology."

Effective Date 4/1/2002

Specialization: Family

103TF0000X Family Psychologist

A psychologist whose specialty is founded on principles of systems theory with the interpersonal system of the family the focus of assessment, intervention and research.

Source: American Psychological Association, www.apa.org [1/1/2019: new definition]

Additional Resources: The APA specialty is "Couple and Family Psychology."

Effective Date 4/1/2002

Behavioral Health & Social Service Providers

Psychologist

Specialization: Forensic

103TF0200X Forensic Psychologist

A psychologist whose specialty is characterized by activities primarily intended to provide professional psychological expertise within the judicial and legal systems.

Source: American Psychological Association, www.apa.org [1/1/2019: new definition]

Effective Date 4/1/2002

Specialization: Group Psychotherapy

103TP2701X Group Psychotherapy Psychologist

A psychologist who specializes in group psychology and group psychotherapy that is an evidenced-based specialty that prepares group leaders to identify and capitalize on developmental and healing possibilities embedded in the interpersonal/intrapersonal functioning of individual group members as well as collectively for the group. Emphasis is placed on the use of group dynamics to assist and treat individual group members. The specialty is applicable to all age groups, children, adolescents, adults and older adults, for a wide variety of conditions and concerns, and in numerous and diverse settings.

Source: American Psychological Association, www.apa.org [1/1/2007: modified title, 1/1/2019: new definition]

Additional Resources: The APA specialty is "Group Psychology and Group Psychotherapy."

Effective Date 4/1/2002 Last Modified Date 1/1/2007

Specialization: Health

103TH0004X Health Psychologist

A psychologist who specializes in clinical health psychology that investigates and implements clinical services across diverse populations and settings to promote health and well-being and to prevent, treat, and manage illness and disability. Clinical health psychology sees health as the confluence of psychological, social, cultural, and biological factors and applies this understanding to professional activities including:
* Research
* Clinical service
* Consulting with, educating, and supervising other health care providers and psychologists
* Advising organizations, institutions, the public, and policymakers

Source: American Psychological Association, www.apa.org [1/1/2007: new, 7/1/2008: definition added, source added, 1/1/2019: definition modified, source modified] Additional Resources: The APA specialty is "Clinical Health Psychology."

Effective Date 4/1/2007

Specialization: Health Service

103TH0100X Health Service Psychologist

A psychologist, certified/licensed at the independent practice level in his/her state, who is duly trained and experienced in the delivery of direct, preventative, assessment, and therapeutic intervention services to individuals whose growth, adjustment, or functioning is actually impaired or is demonstrably at high risk of impairment (1974).

Source: National Register of Health Service Providers in Psychology website http://www.nationalregister.org/about_NR.html [7/1/2006: modified title, added definition]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Behavioral Health & Social Service Providers

Psychologist

Specialization: Intellectual & Developmental Disabilities

103TM1800X **Intellectual & Developmental Disabilities Psychologist**

Definition to come...

[1/1/2021: modified title]

Effective Date 4/1/2002 Last Modified Date 1/1/2021

Specialization: Men & Masculinity

103TM1700X **Deactivated - Psychologist Men & Masculinity**

[1/1/2007: marked inactive]

Effective Date 4/1/2002 Deactivation Date 3/31/2007

Specialization: Prescribing (Medical)

103TP0016X **Prescribing (Medical) Psychologist**

A licensed, doctoral-level psychologist authorized to prescribe and has undergone specialized education and training in preparation for prescriptive practice and has passed an examination accepted by the state board of psychology relevant to establishing competence for prescribing, and has received from the state board of psychology a current certificate granting prescriptive authority, which has not been revoked or suspended.

Source: American Psychological Association, www.apa.org [1/1/2007: new, 1/1/2019: definition modified, source modified]

Effective Date 4/1/2007

Specialization: Psychoanalysis

103TP0814X **Psychoanalysis Psychologist**

A psychologist whose specialty is distinguished from other specialties by its body of knowledge and its intensive treatment approaches. It aims at structural changes and modifications of a person's personality. Psychoanalysis promotes awareness of unconscious, maladaptive and habitually recurrent patterns of emotion and behavior, allowing previously unconscious aspects of the self to become integrated and promoting optimal functioning, healing and creative expression.

Source: American Psychological Association, www.apa.org [1/1/2019, definition modified, source modified]

Effective Date 4/1/2002

Specialization: Psychotherapy

103TP2700X **Deactivated - Psychologist Psychotherapy**

[1/1/2007: marked inactive]

Effective Date 4/1/2002 Deactivation Date 3/31/2007

Behavioral Health & Social Service Providers

Psychologist

Specialization: Rehabilitation

103TR0400X Rehabilitation Psychologist

A psychologist who specializes in the study and application of psychological principles on behalf of persons who have disability due to injury or illness. Rehabilitation psychologists, often within teams, assess and treat cognitive, emotional, and functional difficulties, and help people to overcome barriers to participation in life activities. Rehabilitation psychologists are involved in practice, research, and advocacy, with the broad goal of fostering independence and opportunity for people with disabilities.

Source: American Psychological Association, www.apa.org [1/1/2019: definition added]

Effective Date 4/1/2002

Specialization: School

103TS0200X School Psychologist

A psychologist whose specialty is concerned with the science and practice of psychology with children, youth, families; learners of all ages; and the schooling process. The basic education and training of school psychologists prepares them to provide a range of psychological diagnosis, assessment, intervention, prevention, health promotion, and program development and evaluation services with a special focus on the developmental processes of children and youth within the context of schools, families and other systems. School psychologists are prepared to intervene at the individual and system level, and develop, implement, and evaluate preventive programs. In these efforts, they conduct ecologically valid assessments and intervene to promote positive learning environments within which children and youth from diverse backgrounds to ensure that all have equal access to effective educational and psychological services that promote healthy development

Source: American Psychological Association, www.apa.org [1/1/2019: definition added]

Effective Date 4/1/2002

Specialization: Women

103TW0100X Deactivated - Psychotherapy Women

[1/1/2007: marked inactive]

Effective Date 4/1/2002 Deactivation Date 3/31/2007

Social Worker

104100000X Social Worker

A social worker is a person who is qualified by a Social Work degree, and licensed, certified or registered by the state as a social worker to practice within the scope of that license. A social worker provides assistance and counseling to clients and their families who are dealing with social, emotional and environmental problems. Social work services may be rendered to individuals, families, groups, and the public.

Source: National Association of Social Workers, 2009 [7/1/2009: definition modified]

Effective Date 4/1/2002

Behavioral Health & Social Service Providers

Social Worker

Specialization: Clinical

1041C0700X Clinical Social Worker

A social worker who holds a master's or doctoral degree in social work from an accredited school of social work in addition to at least two years of post-master's supervised experience in a clinical setting. The social worker must be licensed, certified, or registered at the clinical level in the jurisdiction of practice. A clinical social worker provides direct services, including interventions focused on interpersonal interactions, intrapsychic dynamics, and life management issues. Clinical social work services are based on bio-psychosocial perspectives. Services consist of assessment, diagnosis, treatment (including psychotherapy and counseling), client-centered advocacy, consultation, evaluation, and prevention of mental illness, emotional, or behavioral disturbances.

Source: National Association of Social Workers, 2008 [7/1/2009: definition modified]

Effective Date 4/1/2002

Specialization: School

1041S0200X School Social Worker

Definition to come...

#Type!

Effective Date 4/1/2002

Chiropractic Providers

Chiropractor

111N00000X Chiropractor

A provider qualified by a Doctor of Chiropractic (D.C.), licensed by the State and who practices chiropractic medicine -that discipline within the healing arts which deals with the nervous system and its relationship to the spinal column and its interrelationship with other body systems.

#Type!

Effective Date 4/1/2002

Specialization: Independent Medical Examiner

111NI0013X Independent Medical Examiner Chiropractor

A special evaluator not involved with the medical care of the individual examinee that impartially evaluates the care being provided by other practitioners to clarify clinical, disability, liability or other case issues.

Source: American Board of Independent Medical Examiners [1/1/2007: new]

Effective Date 4/1/2007

Chiropractic Providers

Chiropractor

Specialization: Internist

111NI0900X Internist Chiropractor

The chiropractic internist may serve as a primary care physician or may see patients referred from other providers for evaluation and co-management. Evaluation is focused on the early detection of functional, nutritional, and pathological disorders. A chiropractic internist utilizes the diagnostic instruments necessary for proper examination. In cases where laboratory examination is necessary, a chiropractic internist utilizes a recognized reference laboratory facility. A chiropractic internist may manage his or her own cases or may refer to another specialist when prudent to do so. The chiropractic internist utilizes documented natural therapies, therapeutic lifestyle changes, patient education and other resources to promote patient health and avoidance of disease.

Source: American Chiropractic Association, 2008 [7/1/2009: definition added]

Effective Date 4/1/2002

Specialization: Neurology

111NN0400X Neurology Chiropractor

Chiropractic Neurology is defined as the field of functional neurology that engages the internal - and external environment of the individual in a structured and targeted approach to affect positive changes in the nervous system and consequently the physiology and behavior of an individual. Chiropractic Neurologists are board-certified specialists in non-drug, non-surgical care for those with neurologically based health problems. There are many conditions people suffer from that are in this broad category: learning and attention disorders, headaches, vertigo, pain syndromes, developmental disorders, nerve injury, spinal cord injury, head injury or stroke, movement disorders, and many other conditions.

Source: American Chiropractic Neurology Board, 2008 & American Chiropractic Association, 2008 [7/1/2009: definition added]

Effective Date 4/1/2002

Specialization: Nutrition

111NN1001X Nutrition Chiropractor

Chiropractic Nutrition is that specialty within the chiropractic profession that deals with the overall factors that affect the patient's ability to maintain the manipulative correction and thus sustain better neurological integrity. The Chiropractic Nutrition Specialist will perform extensive research on the patient's previous health history, ethnicity, and any family history related to what the patient is being treated for. Patients fill out questionnaires concerning dietary and sleep patterns and previous or present symptomology. A nutrition examination would be performed to assess areas such as absorption rates, adrenal function, kidney health, lung health etc. The patient is often instructed on how to check the pH of their saliva and urine, test for the presence of Candida Albicans, etc., at home. Outside laboratory testing includes blood, urine, hair analysis, food allergy testing etc. The patient's prescription and over the counter medications are recorded and analyzed.

Source: American Chiropractic Association, 2008 [7/1/2009: definition added]

Effective Date 4/1/2002

Chiropractic Providers

Chiropractor

Specialization: Occupational Health

111NX0100X Occupational Health Chiropractor

Occupational Health is that specialty within the chiropractic profession that deals with the prevention and management of work related injuries. It also considers and assists clients with State and Federal Compliance assistance. Occupational Health goes much farther than simply treating injured workers however. This may mean working with clients to promote optimum safety and ergonomic principles, interacting with the injured worker to promote safety and prevent future injuries, assisting a company with accident investigation to identify root cause, redesigning a workstation to eliminate hazards, working with safety teams, providing training programs etc. The list of potential services that the specialist can interact with a client company or patient is lengthy and varied involving both in office services as well as on site services.

Source: American Chiropractic Association, 2008 [7/1/2009: title modified, definition added]

Effective Date 4/1/2002

Specialization: Orthopedic

111NX0800X Orthopedic Chiropractor

Chiropractic Orthopedics is defined as that branch of chiropractic medicine that includes the continued acquisition of knowledge relative to both normal functions and diseases of the human body as they relate to the bones, joints, capsules, discs, muscles, ligaments, tendons, their complete neurological and vascular components, referred organ systems and contiguous tissues. This also includes the development and perfection of skills relative to health maintenance when such exists and when not, the investigations, historical review, physical detection, correlative diagnosis development and complete management of any disorder within the bounds defined herein. Also necessary is the delivery of the combined knowledge and skill on a primary basis to patients who both need and desire this service to the eventual outcome of remissions, whenever resolution is not readily achievable. In addition the certified chiropractic orthopedist provides consultation services at the request of other qualified doctors seeking assistance in the care of their patients. The chiropractic orthopedist may also engage in the teaching and or research of subjects and materials relevant to pursuing the quest for knowledge in the ever changing field of the orthopedic specialty.

Source: American Chiropractic Association, 2008 [7/1/2009: definition added]

Effective Date 4/1/2002

Specialization: Pediatric Chiropractor

111NP0017X Pediatric Chiropractor

The Pediatric Chiropractor is a chiropractor with specialized, advanced training and certification in the evaluation, care and management of health and wellness conditions of infancy, childhood and adolescence. This specialist provides primary, comprehensive, therapeutic and preventative chiropractic health care for newborns through adolescents.

Source: Council on Chiropractic Pediatrics, American Chiropractic Association, 2007 [1/1/2008: new]

Effective Date 4/1/2002

Chiropractic Providers

Chiropractor

Specialization: Radiology

111NR0200X Radiology Chiropractor

Chiropractic radiology is a referral specialty that provides consultation services at the request of other qualified doctors. Chiropractic radiologists provide consultation in health care facilities (private offices, hospitals and teaching institutions) to meet the needs of referring doctors and their patients. The quality of the consultative services by the chiropractic radiologist in independent practice is reflected by the quality of their professional credentials. Chiropractic radiologists recommend, supervise, and interpret radiologic studies as well as advanced imaging procedures. They advise referring physicians on the necessity and appropriateness of radiologic services and whether to select or to avoid certain diagnostic or clinical procedures. In some instances the radiologist may act as a private practitioner. They may conduct research and apply diagnostic radiologic procedures and may be called upon to act as expert witnesses in matters of litigation.

Chiropractic radiologists are also concerned with imaging technology including image production, demonstration of normal and abnormal anatomy, and the interaction of energy and matter. The advances in the technological facets of radiology are so rapid that only qualified radiologists can reasonably be expected to maintain the high level of proficiency required to supervise and interpret these procedures. The practice of radiology continuously involves the application of this technology to patient imaging and treatment. It is now well recognized that chiropractic radiology includes, but is not limited to, plain film radiography, fluoroscopy, tomography, ultrasonography, radioisotope imaging, computed tomography, digital radiography, and magnetic resonance imaging. Individual practices may vary by intent, licensure, and scope of practice laws.

Source: American Chiropractic Board of Radiology, 2009 [7/1/2009: definition added]

Effective Date 4/1/2002

Specialization: Rehabilitation

111NR0400X Rehabilitation Chiropractor

Rehabilitation is the discipline focused on restoring a patient's functional abilities to pre-injury or pre-disease status. Functional abilities are defined as those activities in one's daily life, work, or sports and recreational activities that an individual participates in. Relevant impairments (e.g. strength, endurance, flexibility, motor control, etc.) are often intermediate goals of rehabilitation, but the final goal of successful care is return to participation in activities in which the patient was successful before the onset of the injury or disease. Essential to a rehabilitation approach is a focus on patient-centered outcomes such as independence and self-management or self-care skills.

Source: The American Chiropractic Association (ACA) and the ACA Council on Physiological Therapeutics [7/1/2006: new]

Effective Date 10/1/2006

Chiropractic Providers

Chiropractor

Specialization: Sports Physician

111NS0005X Sports Physician Chiropractor

A sports chiropractor is uniquely trained to provide care and treatment of injuries or illness resulting from sports and physical fitness activities. Doctors of Chiropractic with the Diplomate American Chiropractic Board of Sports Physicians (DACBSP) or the Certified Chiropractic Sports Physician (CCSP), sport specialty certifications from the American Chiropractic Board of Sports Physicians, have advanced training in the assessment, management and rehabilitation of sports related injuries. Extremity care, rehabilitation and soft tissue procedures are common skills utilized by these doctors. The specialty training covers a broad spectrum from the pediatric athlete to professional and Olympic athletes, and everything in between, using a variety of techniques and modalities.

Source: American Chiropractic Board of Sports Physicians, 2009 [7/1/2009: definition added]

Effective Date 4/1/2002

Specialization: Thermography

111NT0100X Thermography Chiropractor

The NUCC recommends this code not be used. Choose a more appropriate code.

#Type!

Effective Date 4/1/2002 Last Modified Date 1/1/2023

Dental Providers

Advanced Practice Dental Therapist

125K00000X Advanced Practice Dental Therapist

An Advanced Practice Dental Therapist is:

(1) A dental therapist who has completed additional training beyond basic dental therapy education and provides dental services in accordance with state advanced practice dental therapist laws or statutes; or

(2) A dental hygienist with a graduate degree in advanced dental therapy prepared for independent and interdependent decision making and direct accountability for clinical judgment across the dental health care continuum.

The individual has been authorized by the relevant state board or a tribal entity to provide services under the remote supervision of a dentist. The functions of the advanced practice dental therapist vary based on the needs of the dentist, the educational preparation of the advanced practice dental therapist and state dental practice acts and regulations.

Source: Summarized from Minnesota Statute 150A.106. [7/1/2012: new]

Effective Date 10/1/2012

Dental Providers

Dental Assistant

126800000X Dental Assistant

An individual who may or may not have completed an accredited dental assisting education program and who aids the dentist in providing patient care services and performs other nonclinical duties in the dental office or other patient care facility. The scope of the patient care functions that may be legally delegated to the dental assistant varies based on the needs of the dentist the educational preparation of the dental assistant and state dental practice acts and regulations. Patient care services are provided under the supervision of a dentist. To avoid misleading the public, no occupational title other than dental assistant should be used to describe this dental auxiliary.

Source: Comprehensive Policy Statement on Dental Auxiliaries, American Dental Association

Effective Date 4/1/2002

Dental Hygienist

124Q00000X Dental Hygienist

An individual who has completed an accredited dental hygiene education program, and an individual who has been licensed by a state board of dental examiners to provide preventive care services under the supervision of a dentist. Functions that may be legally delegated to the dental hygienist vary based on the needs of the dentist, the educational preparation of the dental hygienist and state dental practice acts and regulations, but always include, at a minimum, scaling and polishing the teeth. To avoid misleading the public, no occupational title other than dental hygienist should be used to describe this dental auxiliary.

Source: Comprehensive Policy Statement on Dental Auxiliaries, American Dental Association.

Effective Date 4/1/2002

Dental Laboratory Technician

126900000X Dental Laboratory Technician

An individual who has the skill and knowledge in the fabrication of dental appliances, prostheses and devices in accordance with a dentist's laboratory work authorization. To avoid misleading the public, no occupational title other than dental laboratory technician or certified dental technician (when appropriate) should be used to describe this auxiliary.

Source: Comprehensive Policy Statement on Dental Auxiliaries, American Dental Association.

Effective Date 4/1/2002

Dental Therapist

125J00000X Dental Therapist

A Dental Therapist is an individual who has completed an accredited or non-accredited dental therapy program and who has been authorized by the relevant state board or a tribal entity to provide services within the scope of their practice under the supervision of a dentist. Functions that may be delegated to the dental therapist vary based on the needs of the dentist, the educational preparation of the dental therapist and state dental practice acts and regulations.

Source: Summarized from Minnesota Statute 150A.105. [7/1/2012: new]

Effective Date 10/1/2012

Dental Providers

Dentist

122300000X Dentist

A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.), licensed by the state to practice dentistry, and practicing within the scope of that license. There is no difference between the two degrees: dentists who have a DMD or DDS have the same education. Universities have the prerogative to determine what degree is awarded. Both degrees use the same curriculum requirements set by the American Dental Association's Commission on Dental Accreditation. Generally, three or more years of undergraduate education plus four years of dental school is required to graduate and become a general dentist. State licensing boards accept either degree as equivalent, and both degrees allow licensed individuals to practice the same scope of general dentistry. Additional post-graduate training is required to become a dental specialist.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Specialization: Dental Public Health

1223D0001X Public Health Dentist

The science and art of preventing and controlling dental diseases and promoting dental health through organized community efforts. It is that form of dental practice that serves the community as a patient rather than the individual. It is concerned with the dental health education of the public, with applied dental research, and with the administration of group dental care programs as well as the prevention and control of dental diseases on a community basis.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Specialization: Dentist Anesthesiologist

1223D0004X Dentist Anesthesiologist

A dentist who has successfully completed an accredited postdoctoral anesthesiology residency training program for dentists of two or more years duration, in accord with Commission on Dental Accreditation's Standards for Dental Anesthesiology Residency Programs, and/or meets the eligibility requirements for examination by the American Dental Board of Anesthesiology.

Source: The American Society of Dentist Anesthesiologists [1/1/2013: new]

Effective Date 4/1/2013

Specialization: Endodontics

1223E0200X Endodontist

The branch of dentistry that is concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues. Its study and practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Dental Providers

Dentist

Specialization: General Practice

1223G0001X General Practice Dentistry

A general dentist is the primary dental care provider for patients of all ages. The general dentist is responsible for the diagnosis, treatment, management and overall coordination of services related to patients' oral health needs.

Source: Academy of General Dentistry

Effective Date 4/1/2002

Specialization: Oral and Maxillofacial Pathology

1223P0106X Oral and Maxillofacial Pathology Dentist

The specialty of dentistry and discipline of pathology that deals with the nature, identification, and management of diseases affecting the oral and maxillofacial regions. It is a science that investigates the causes, processes, and effects of these diseases. The practice of oral and maxillofacial pathology includes research and diagnosis of diseases using clinical, radiographic, microscopic, biochemical, or other examinations.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Specialization: Oral and Maxillofacial Radiology

1223X0008X Oral and Maxillofacial Radiology Dentist

The specialty of dentistry and discipline of radiology concerned with the production and interpretation of images and data produced by all modalities of radiant energy that are used for the diagnosis and management of diseases, disorders and conditions of the oral and maxillofacial region.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Specialization: Oral and Maxillofacial Surgery

1223S0112X Oral and Maxillofacial Surgery (Dentist)

The specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Dental Providers

Dentist

Specialization: Orofacial Pain

1223X2210X Orofacial Pain Dentist

A dentist who assesses, diagnoses, and treats patients with complex chronic orofacial pain and dysfunction disorders, oromotor and jaw behavior disorders, and chronic head/neck pain. The dentist has successfully completed an accredited postdoctoral orofacial pain residency training program for dentists of two or more years duration, in accord with the Commission on Dental Accreditation's Standards for Orofacial Pain Residency Programs, and/or meets the requirements for examination and board certification by the American Board of Orofacial Pain.

Source: American Academy of Orofacial Pain, http://www.aaop.org [7/1/2019: new]

Additional Resources: American Board of Orofacial Pain, http://www.abop.net

Effective Date 10/1/2019

Specialization: Orthodontics and Dentofacial Orthopedics

1223X0400X Orthodontics and Dentofacial Orthopedic Dentist

That area of dentistry concerned with the supervision, guidance and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and the adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex. Major responsibilities of orthodontic practice include the diagnosis, prevention, interception and treatment of all forms of malocclusion of the teeth and associated alterations in their surrounding structures; the design, application and control of functional and corrective appliances; and the guidance of the dentition and its supporting structures to attain and maintain optimum occlusal relations in physiologic and esthetic harmony among facial and cranial structures.

#Type!

Effective Date 4/1/2002

Specialization: Pediatric Dentistry

1223P0221X Pediatric Dentist

An age-defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Specialization: Periodontics

1223P0300X Periodontist

That specialty of dentistry which encompasses the prevention, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and esthetics of these structures and tissues.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Dental Providers

Dentist

Specialization: Prosthodontics

1223P0700X Prosthodontist

That branch of dentistry pertaining to the restoration and maintenance of oral functions, comfort, appearance and health of the patient by the restoration of natural teeth and/or the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Denturist

122400000X Denturist

A denturist is a licensed professional that serves patients with removable dental prosthetic oral health needs. A licensed denturist is trained in removable dental prosthetics and the fabrication of such devices.

Source: National Denturist Association, https://nationaldenturist.com/ [1/1/2024: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Oral Medicinist

125Q00000X Oral Medicinist

A dentist with advanced training specializing in the recognition and treatment of oral conditions resulting from the interrelationship between oral disease and systemic health. The Oral Medicinist manages clinical and non-surgical treatment of non-dental pathologies affecting the oral and maxillofacial region, such as cancer, organ transplants, and acute and chronic pain. Activities include provision of interdisciplinary patient care in collaboration with medical specialists and other dentists in hospitals and outpatient medical clinics in the management of patients with complex medical conditions requiring multidisciplinary healthcare intervention.

Source: National Uniform Claim Committee [1/1/2015: new] Additional Resources: American Academy of Oral Medicine

Effective Date 4/1/2015

Dietary & Nutritional Service Providers

Dietary Manager

132700000X Dietary Manager

A dietary manager is a trained food services professional who is charged with maintaining cost/profit objectives, purchasing foods and services for the department and supervising staff.. Dietary managers are trained to understand the basic nutritional needs of clients and work in partnership with dietitians, who offer specialized nutritional expertise. The CDM certified dietary manager designation is an advanced professional credential awarded to dietary managers who have completed specific course work, have passed the national credentialing exams (including a sanitation and safety exam) and have applied for certification.

#Type!

Effective Date 4/1/2002

Dietetic Technician, Registered

136A00000X Registered Dietetic Technician

A Dietetic Technician, Registered (DTR)/Nutrition and Dietetics Technician, Registered (NDTR) is an individual holding a nationally protected title issued by the Commission on Dietetic Registration (CDR) to qualified individuals who obtain an associate's degree or higher and successfully complete a sliding set of academic, examination, and practice requirements accredited by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) or established by CDR, the nature of which are dependent upon the level of academic degree obtained. The scope of practice of the NDTR focuses on food, nutrition, and dietetics practice, as well as related services. NDTRs work under the supervision of a Registered Dietitian Nutritionist (RDN) when in direct patient/client nutrition care, and may work independently in providing general nutrition education to healthy populations. Patient/client populations include individuals receiving individualized care who have medical conditions or diseases, as well as at-risk individuals receiving personalized nutrition guidance as part of preventive health care.

Source: Academy of Nutrition and Dietetics Definition of Terms List, Current Version, https://www.eatrightpro.org/practice/quality-management/scope-of-practice [7/1/2019:modified definition]

Effective Date 4/1/2002 Last Modified Date 7/1/2019

Dietitian, Registered

133V00000X Registered Dietitian

A Registered Dietitian (RD)/Registered Dietitian Nutritionist (RDN) is an individual uniquely trained in the science of nutrition and practice of dietetics to design and provide medical nutrition therapy (MNT) and other evidence-based applications of the Nutrition Care Process (NCP) that exemplify the profession's systematic approach to providing high quality nutrition care. Registered dietitians provide MNT for the purpose of disease prevention or management, or to treat or rehabilitate an illness, injury, or condition, with the use of specific, indicated physical and cognitive nutrition care services comprised of one or more of the following aspects of the NCP: nutrition assessment/reassessment, nutrition diagnosis, nutrition intervention (e.g., nutrition counseling, therapeutic diet ordering, and nutrition education) and nutrition monitoring and evaluation.

Source: Academy of Nutrition and Dietetics Definition of Terms List , Current Version, https://www.eatrightpro.org/practice/quality-management/scope-of-practice [7/1/2019:modified definition]

Effective Date 4/1/2002 Last Modified Date 7/1/2019

Dietary & Nutritional Service Providers

Dietitian, Registered

Specialization: Nutrition, Gerontological

133VN1101X Gerontological Nutrition Registered Dietitian

An individual who is a Specialist in Gerontological Nutrition and provides nutrition care to promote quality of life and optimal health for older adults across the continuum of care, including: acute care, post-acute care, primary care, long-term care, assisted living, home care, palliative care, community-based nutrition, food service, correctional facilities, and government programs. RDN who works indirectly with gerontological nutrition through roles in management, industry, education, and research.

Source: The Commission on Dietetic Registration, https://www.cdrnet.org/certifications/specialty-practice-experience [7/1/2019: new]

Effective Date 10/1/2019

Specialization: Nutrition, Metabolic

133VN1006X Metabolic Nutrition Registered Dietitian

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Nutrition, Obesity and Weight Management

133VN1201X Obesity and Weight Management Nutrition Registered Dietitian

An individual who is a Board Certified Specialist for Obesity and Weight Management and educates, supports, and advocates for patients and clients to understand and manage their weight and associated risks through the use of nutritional, behavioral health, medical, surgical, pharmacotherapeutic, and exercise and physical activity interventions.

Source: The Commission on Dietetic Registration, https://www.cdrnet.org/certifications/specialty-practice-experience [7/1/2019: new]

Effective Date 10/1/2019

Specialization: Nutrition, Oncology

133VN1301X Oncology Nutrition Registered Dietitian

An individual who is a Board Certified Specialist in Oncology Nutrition and provides direct nutrition care for individuals at risk for or diagnosed with cancer. RDNs working directly with individuals at risk for, or diagnosed with, any type of malignancy or pre-malignant condition, in a variety of settings (e.g. hospitals, clinics, cancer centers, hospices, public health), OR indirectly through roles in management, education, industry, and research practice linked specifically to oncology nutrition. RDN who works indirectly with oncology nutrition through roles in management, education, industry, and research.

Source: The Commission on Dietetic Registration, https://www.cdrnet.org/certifications/specialty-practice-experience [7/1/2019: new]

Effective Date 10/1/2019

Dietary & Nutritional Service Providers

Dietitian, Registered

Specialization: Nutrition, Pediatric

133VN1004X Pediatric Nutrition Registered Dietitian

An individual who is a Board Certified Specialist in Pediatric Nutrition and applies evidence-based nutrition knowledge in providing medical nutrition therapy for pediatric patients. Specialists work directly with healthy and/or ill children (newborn up to 21 years of age) as well as children with special health care needs in a variety of settings (hospitals, community-based and/or family-centered programs, education programs, home, etc.), OR indirectly through management, care coordination, education, quality improvement, or research practice linked specifically to pediatric nutrition.

Source: The Commission on Dietetic Registration, https://www.cdrnet.org/certifications/specialty-practice-experience [7/1/2019: definition added, source added]

Effective Date 4/1/2002 Last Modified Date 7/1/2019

Specialization: Nutrition, Pediatric Critical Care

133VN1401X Pediatric Critical Care Nutrition Registered Dietitian

An individual who is a Board Certified Specialist in Pediatric Critical Care Nutrition and applies evidence-based nutrition knowledge in providing medical nutrition therapy for critically ill infants, children and adolescents. Additional roles could include coordination, education, quality improvement, or research linked specifically to pediatric critical care nutrition.

Source: The Commission on Dietetic Registration, https://www.cdrnet.org/certifications/specialty-practice-experience [7/1/2019: new]

Effective Date 10/1/2019

Specialization: Nutrition, Renal

133VN1005X Renal Nutrition Registered Dietitian

An individual who is a Board Certified Specialist in Renal Nutrition and works directly with adult and/or pediatric patients with acute kidney injury, chronic kidney disease (CKD) stages 1-5, or receiving renal replacement therapies (dialysis/transplant) in a variety of settings, OR works indirectly in management, education, or research practice linked specifically to renal nutrition. The specialist in renal/nephrology nutrition is responsible for nutrition assessment, diagnosis, intervention, monitoring, and evaluation.

Source: The Commission on Dietetic Registration, https://www.cdrnet.org/certifications/specialty-practice-experience [7/1/2019: definition added, source added]

Effective Date 4/1/2002 Last Modified Date 7/1/2019

Specialization: Nutrition, Sports Dietetics

133VN1501X Sports Dietetics Nutrition Registered Dietitian

An individual who is a Board Certified Specialist in Sports Dietetics and applies evidence-based nutrition knowledge in exercise and sports. RDNs specializing in sports dietetics assess, educate, and counsel athletes and active individuals. They design, implement, and manage safe and effective nutrition strategies that enhance lifelong health, fitness, and optimal performance.

Source: The Commission on Dietetic Registration, https://www.cdrnet.org/certifications/specialty-practice-experience [7/1/2019: new]

Effective Date 10/1/2019

Dietary & Nutritional Service Providers

Nutritionist

133N00000X Nutritionist

A specialist in adapting and applying food and nutrient knowledge to the solution of food and nutritional problems, the control of disease, and the promotion of health. Nutritionists perform research, instruct groups and individuals about nutritional requirements, and assist people in developing meal patterns that meet their nutritional needs; (2) A nutritionist is someone who has completed undergraduate and/or graduate training in the discipline of nutrition without necessarily meeting the academic and experience requirements to qualify for the Registered Dietitian designation.

Source: (1) Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Specialization: Nutrition, Education

133NN1002X Nutrition Education Nutritionist

Definition to come...

#Type!

Effective Date 4/1/2002

Emergency Medical Service Providers

Emergency Medical Technician, Basic

146N00000X Basic Emergency Medical Technician

A Basic EMT is an individual trained and certified to perform basic life support treatment in medical emergencies based on individual state boards.

Sources: Tabers Medical Dictionary and Florida EMS Clearing House.

Effective Date 4/1/2002

Emergency Medical Technician, Intermediate

146M00000X Intermediate Emergency Medical Technician

An Intermediate EMT is an individual trained and certified to perform intermediate life support treatment in medical emergencies based on individual state boards.

Sources: Tabers Medical Dictionary and Florida EMS Clearing House.

Effective Date 4/1/2002

Emergency Medical Service Providers

Emergency Medical Technician, Paramedic

146L00000X Paramedic

An EMT, Paramedic is an individual trained and certified to perform advanced life support (ALS) in medical emergencies based on individual state boards.

Sources: Tabers Medical Dictionary and Florida EMS Clearing House.

Effective Date 4/1/2002

Personal Emergency Response Attendant

146D00000X Personal Emergency Response Attendant

Individuals that are specially trained to assist patients living at home with urgent/emergent situations. These individuals must be able to perform CPR and basic first aid and have sufficient counseling skills to allay fears and assist in working through processes necessary to resolve the crisis. Functions may include transportation to various facilities and businesses, contacting agencies to initiate remediation service or providing reassurance.

#Type!

Effective Date 4/1/2002

Eye and Vision Services Providers

Optometrist

152W00000X Optometrist

Doctors of optometry (ODs) are the primary health care professionals for the eye. Optometrists examine, diagnose, treat, and manage diseases, injuries, and disorders of the visual system, the eye, and associated structures as well as identify related systemic conditions affecting the eye. An optometrist has completed pre-professional undergraduate education in a college or university and four years of professional education at a college of optometry, leading to the doctor of optometry (O.D.) degree. Some optometrists complete an optional residency in a specific area of practice. Optometrists are eye health care professionals state-licensed to diagnose and treat diseases and disorders of the eye and visual system.

Source: American Optometric Association (AOA), approved by the AOA's Board of Trustees, June 21, 2005. [7/1/2006: definition modified]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Specialization: Corneal and Contact Management

152WC0802X Corneal and Contact Management Optometrist

The professional activities performed by an Optometrist related to the fitting of contact lenses to an eye, ongoing evaluation of the cornea's ability to sustain successful contact lens wear, and treatment of any external eye or corneal condition which can affect contact lens wear.

Source: American Optometric Association [1/1/2009: added definition, added source]

Effective Date 4/1/2002 Last Modified Date 1/1/2009

Eye and Vision Services Providers

Optometrist

Specialization: Low Vision Rehabilitation

152WL0500X Low Vision Rehabilitation Optometrist

Optometrists who specialize in low-vision care having training to assess visual function, prescribe low-vision devices, develop treatment plans, and recommend other vision rehabilitation services.

Source: American Optometric Association [1/1/2009: added definition, added source]

Effective Date 4/1/2002 Last Modified Date 1/1/2009

Specialization: Occupational Vision

152WX0102X Occupational Vision Optometrist

Optometrists who work in Occupational Vision, the branch of environmental optometry, consider all aspects of the relationship between work and vision, visual performances, eye safety, and health.

Source: American Optometric Association [1/1/2009: added definition, added source]

Effective Date 4/1/2002 Last Modified Date 1/1/2009

Specialization: Pediatrics

152WP0200X Pediatric Optometrist

Optometrists who work in Pediatrics are concerned with the prevention, development, diagnosis, and treatment of visual problems in children.

Source: American Optometric Association [1/1/2009: added definition, added source]

Effective Date 4/1/2002 Last Modified Date 1/1/2009

Specialization: Sports Vision

152WS0006X Sports Vision Optometrist

An optometrist who offers services designed to care for unique vision care needs of athletes, which may include one of more of the following services: corrective vision care unique to a specific sporting environment; protective eyewear for the prevention of sports-related injuries; vision enhancement - which may include vision therapy and techniques to improve visual skills specific to the athlete's sport.

Source: American Optometric Association [1/1/2009: added definition, added source]

Effective Date 4/1/2002 Last Modified Date 1/1/2009

Specialization: Vision Therapy

152WV0400X Vision Therapy Optometrist

Optometrists who specialize in vision therapy as a treatment process used to improve vision function. It includes a broad range of developmental and rehabilitative treatment programs individually prescribed to remediate specific sensory, motor and/or visual perceptual dysfunctions.

Source: American Optometric Association [1/1/2009: added definition, added source]

Effective Date 4/1/2002 Last Modified Date 1/1/2009

Eye and Vision Services Providers

Technician/Technologist

156F00000X Technician/Technologist

A broad category grouping different kinds of technologists and technicians. See individual definitions.

#Type!

Effective Date 4/1/2002

Specialization: Contact Lens

156FC0800X Contact Lens Technician/Technologist

An optician or other ancillary support staff person who, where authorized by state law and trained or certified to do so, may fit or dispense contact lenses to a patient based on the prescription of an optometrist or medical physician.

Source: American Optometric Association [1/1/2009: added definition, added source]

Effective Date 4/1/2002 Last Modified Date 1/1/2009

Specialization: Contact Lens Fitter

156FC0801X Contact Lens Fitter

An optician or other ancillary support staff person who, where authorized by state law and trained or certified to do so, may fit or dispense contact lenses to a patient based on the prescription of an optometrist or medical physician.

Source: American Optometric Association [1/1/2009: added definition, added source]

Effective Date 4/1/2002 Last Modified Date 1/1/2009

Specialization: Ocularist

156FX1700X Ocularist

An ocularist is a thoroughly trained professional skilled in the art of fitting, painting, and fabricating custom ocular prostheses. In addition to creating custom ocular prostheses, and providing long-term care through periodic examinations, an ocularist provides the patient with complete instructions on the care and maintenance of their prosthesis.

Source: American Society of Ocularists, www.ocularist.org [7/1/2023: definition added]

Effective Date 4/1/2002 Last Modified Date 7/1/2023

Specialization: Ophthalmic

156FX1100X Ophthalmic Technician/Technologist

An ophthalmic technician/technologist assists ophthalmologists by performing ophthalmic clinical functions, including administering eye exams, administering eye medications, and instructing the patient in care and use of corrective lenses.

Source: Bureau of Labor Statistics, https://www.bls.gov/oes/current/oes292057.htm [1/1/2024: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Eye and Vision Services Providers

Technician/Technologist

Specialization: Ophthalmic Assistant

156FX1101X Ophthalmic Assistant

An ophthalmic assistant assists ophthalmologists by performing duties including, but not limited to, patient charting, patient education, and basic eye testing.

Source: National Uniform Claim Committee [1/1/2024: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Specialization: Optician

156FX1800X Optician

Opticians help fit eyeglasses and contact lenses, following prescriptions from Ophthalmologists and Optometrists. They also help customers decide which eyeglass frame or contact lenses to buy.

Source: U.S. Bureau of Labor Statistics, www.bls.gov. [7/1/2023: definition added]

Effective Date 4/1/2002 Last Modified Date 7/1/2023

Specialization: Optometric Assistant

156FX1201X Optometric Assistant Technician

An optometric assistant assists optometrists by performing duties, including but not limited to, customer service, basic eye testing, and patient education.

Source: National Uniform Claim Committee [1/1/2024: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Specialization: Optometric Technician

156FX1202X Optometric Technician

An optometric technician assists optometrists by performing duties, including but not limited to, basic eye testing, diagnostic tests, and assistance with corrective lenses.

Source: National Uniform Claim Committee [1/1/2024: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Specialization: Orthoptist

156FX1900X Orthoptist

An orthoptist is an allied health professional skilled in evaluation and treatment of children and adults with eye movement difficulties. Their specialty is strabismus, amblyopia, and double vision.

Source: American Association of Certified Orthoptists, www.orthoptics.org [7/1/2023: definition added]

Effective Date 4/1/2002 Last Modified Date 7/1/2023

Group

Multi-Specialty

193200000X Multi-Specialty Group

A business group of one or more individual practitioners, who practice with different areas of specialization.

[7/1/2003: new]

Effective Date 10/1/2003

Single Specialty

193400000X Single Specialty Group

A business group of one or more individual practitioners, all of who practice with the same area of specialization.

[7/1/2003: new]

Effective Date 10/1/2003

Nursing Service Providers

Licensed Practical Nurse

164W00000X Licensed Practical Nurse

An individual with post-high school vocational training and practical experience in the provision of nursing care at a level less than that required for certification as a Registered Nurse. Requirements for education, experience, licensure, and job responsibilities vary among the states.

Source: Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Licensed Psychiatric Technician

167G00000X Licensed Psychiatric Technician

An individual licensed by the state board as a Psychiatric Technician based upon completion of a prescribed course of theory and clinical practice, with two thirds of the clinical practice time focused on mental and developmental disorders. The psychiatric technician practices under the direct supervision of a physician, psychologist, registered nurse or other professional to provide care to patients with mental disorders and developmental disabilities.

#Type!

Effective Date 4/1/2002

Nursing Service Providers

Licensed Vocational Nurse

164X00000X Licensed Vocational Nurse

An individual with post-high school vocational training and practical experience in the provision of nursing care at a level less than that required for certification as a Registered Nurse. [An alternate term for licensed practical nurse arising from difference in occupational titles between states and post-high school training programs and institutions.] Requirements for education, experience, licensure, and job responsibilities vary among the states.

Source: Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Registered Nurse

163W00000X Registered Nurse

(1) A registered nurse is a person qualified by graduation from an accredited nursing school (depending upon schooling, a registered nurse may receive either a diploma from a hospital program, an associate degree in nursing (A.D.N.) or a Bachelor of Science degree in nursing (B.S.N.), who is licensed or certified by the state, and is practicing within the scope of that license or certification. R.N.'s assist patient in recovering and maintaining their physical or mental health. They assist physicians during treatments and examinations and administer medications. (2) A provider who is trained and educated in a formal nursing education program at an accredited school of nursing, passes a national certification examination, and is licensed by the state to practice nursing. The individual provides nursing services to patients or clients in areas such as health promotion, disease prevention, acute and chronic care and restoration and maintenance of health across the life span.

Sources: (2) American Nurses Association, American Nurses Credentialing Center, 1996 Certification Catalogue, and Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Specialization: Addiction (Substance Use Disorder)

163WA0400X Addiction (Substance Use Disorder) Registered Nurse

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Administrator

163WA2000X Administrator Registered Nurse

Definition to come...

#Type!

Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Ambulatory Care
163WP2201X **Ambulatory Care Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Cardiac Rehabilitation
163WC3500X **Cardiac Rehabilitation Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Case Management
163WC0400X **Case Management Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: College Health
163WC1400X **College Health Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Community Health
163WC1500X **Community Health Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Continence Care
163WC2100X **Continence Care Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Continuing Education/Staff Development

163WC1600X **Continuing Education/Staff Development Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Critical Care Medicine

163WC0200X **Critical Care Medicine Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Diabetes Educator

163WD0400X **Diabetes Educator Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Dialysis, Peritoneal

163WD1100X **Peritoneal Dialysis Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Emergency

163WE0003X **Emergency Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Enterostomal Therapy

163WE0900X **Enterostomal Therapy Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Flight

163WF0300X **Flight Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Gastroenterology

163WG0100X **Gastroenterology Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: General Practice

163WG0000X **General Practice Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Gerontology

163WG0600X **Gerontology Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Hemodialysis

163WH0500X **Hemodialysis Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Home Health

163WH0200X **Home Health Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Hospice

163WH1000X **Hospice Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Infection Control

163WI0600X **Infection Control Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Infusion Therapy

163WI0500X **Infusion Therapy Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Lactation Consultant

163WL0100X **Lactation Consultant (Registered Nurse)**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Maternal Newborn

163WM0102X **Maternal Newborn Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Medical-Surgical

163WM0705X **Medical-Surgical Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Neonatal Intensive Care
163WN0002X **Neonatal Intensive Care Registered Nurse**
Definition to come...
#Type!
Effective Date 4/1/2002

Specialization: Neonatal, Low-Risk
163WN0003X **Low-Risk Neonatal Registered Nurse**
Definition to come...
#Type!
Effective Date 4/1/2002

Specialization: Nephrology
163WN0300X **Nephrology Registered Nurse**
Definition to come...
#Type!
Effective Date 4/1/2002

Specialization: Neuroscience
163WN0800X **Neuroscience Registered Nurse**
Definition to come...
#Type!
Effective Date 4/1/2002

Specialization: Nurse Massage Therapist (NMT)
163WM1400X **Nurse Massage Therapist (NMT)**
Definition to come...
#Type!
Effective Date 4/1/2002

Specialization: Nutrition Support
163WN1003X **Nutrition Support Registered Nurse**
Definition to come...
#Type!
Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Obstetric, High-Risk
163WX0002X **High-Risk Obstetric Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Obstetric, Inpatient
163WX0003X **Inpatient Obstetric Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Occupational Health
163WX0106X **Occupational Health Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Oncology
163WX0200X **Oncology Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Ophthalmic
163WX1100X **Ophthalmic Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Orthopedic
163WX0800X **Orthopedic Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Ostomy Care
163WX1500X **Ostomy Care Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Otorhinolaryngology & Head-Neck
163WX0601X **Otorhinolaryngology & Head-Neck Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Pain Management
163WP0000X **Pain Management Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Pediatric Oncology
163WP0218X **Pediatric Oncology Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Pediatrics
163WP0200X **Pediatric Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Perinatal
163WP1700X **Perinatal Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Plastic Surgery

163WS0121X **Plastic Surgery Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health

163WP0808X **Psychiatric/Mental Health Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health, Adult

163WP0809X **Adult Psychiatric/Mental Health Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health, Child & Adolescent

163WP0807X **Child & Adolescent Psychiatric/Mental Health Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Registered Nurse First Assistant

163WR0006X **Registered Nurse First Assistant**

A perioperative registered nurse who works in collaboration with the surgeon and other health care team members to achieve optimal outcomes. The RNFA has acquired the necessary knowledge, judgment, and skills specific to the expanded role of RNFA clinical practice. Intraoperatively, the RNFA assists the surgeon.

Source: AORN Official Statement on RNFAs ratified by the AORN House of Delegates in 2004. [7/1/2006: new]

Effective Date 10/1/2006

Specialization: Rehabilitation

163WR0400X **Rehabilitation Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Nursing Service Providers

Registered Nurse

Specialization: Reproductive Endocrinology/Infertility
163WR1000X **Reproductive Endocrinology/Infertility Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: School
163WS0200X **School Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Urology
163WU0100X **Urology Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Women's Health Care, Ambulatory
163WW0101X **Ambulatory Women's Health Care Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Wound Care
163WW0000X **Wound Care Registered Nurse**

Definition to come...

#Type!

Effective Date 4/1/2002

Nursing Service Related Providers

Adult Companion

372600000X Adult Companion

An individual who provides supervision, socialization, and non-medical care to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. These services are provided in accordance with a therapeutic goal in the plan of care.

[7/1/2003: new]

Effective Date 10/1/2003

Chore Provider

372500000X Chore Provider

An individual who provides home maintenance services required to sustain a safe, sanitary living environment for individuals who because of age or disabilities is unable to perform the activities. These services include heavy household chores such as washing floors, windows, and walls; tacking down loose rugs and tiles; and moving heavy items of furniture in order to provide safe access and egress.

[7/1/2003: new]

Effective Date 10/1/2003

Day Training/Habilitation Specialist

373H00000X Day Training/Habilitation Specialist

Individuals experienced or trained in working with developmentally disabled individuals who need assistance in acquiring and maintaining life skills that enable them to cope more effectively with the demands of independent living.

#Type!

Effective Date 4/1/2002

Doula

374J00000X Doula

Doulas work in a variety of settings and have been trained to provide physical, emotional, and informational support to a mother before, during, and just after birth and/or provide emotional and practical support to a mother during the postpartum period.

Source: National Uniform Claim Committee, 2009 [7/1/2009: new]

Effective Date 10/1/2009

Nursing Service Related Providers

Home Health Aide

374U00000X Home Health Aide

A person trained to assist public health nurses, home health nurses, and other health professionals in the bedside care of patients in their homes.

Source: Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Homemaker

376J00000X Homemaker

An individual who provides general household activities such as meal preparation, laundry, and light housekeeping, when the individual regularly responsible for these activities is temporarily absent or unable to provide for himself. Homemakers must meet the state defined training standards.

[7/1/2003: definition added]

Effective Date 4/1/2002 Last Modified Date 7/1/2003

Nurse's Aide

376K00000X Nurse's Aide

(1) An unlicensed individual who is trained to function in an assistive role to the licensed nurse in the provision of patient/client activities as delegated by the nurse; (2) An individual trained (either on-the-job or through a formal course generally of less than one year) and experienced in performing patient or client-care nursing tasks that do not require the skills of a specialist, technician, or professional. Examples of tasks performed by nurses aides include changing clothes, diapers, and beds; assisting patients to perform exercises or personal hygiene tasks, and supporting communication or social interaction. Specific education and credentials are not required for this work.

Source: (1) American Nurses Association, Registered Professional Nurses and Unlicensed Personnel, 2nd ed., 1996; (2) Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Nursing Home Administrator

376G00000X Nursing Home Administrator

An individual, often licensed by the state, who is responsible for the management of a nursing home.

Source: Lexikon: Dictionary of Health Care Terms, Organizations, and Acronyms for the Era of Reform, Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL, 1994, p. 552.

Effective Date 4/1/2002

Nursing Service Related Providers

Religious Nonmedical Nursing Personnel

374T00000X Religious Nonmedical Nursing Personnel

Religious nonmedical nursing personnel are experienced in caring for the physical needs of nonmedical patients. For example, caring for the physical needs such as assistance with activities of daily living; assistance with moving, positioning, and ambulation; nutritional needs; and comfort and support measures.

Source: Centers for Medicare & Medicaid Services [7/1/2009: title modified, definition modified] Additional Resources: www.cms.hhs.gov/CertificationandComplianc/19_RNHCIs.asp 2005 Code of Federal Regulations, Title 42, Chapter IV, Part 403, Subpart G, 403.702 Definitions and Terms

Effective Date 4/1/2002

Religious Nonmedical Practitioner

374K00000X Religious Nonmedical Practitioner

A religious nonmedical practitioner offers spiritually-based care. Services may be rendered in an office, home, or care facility or by phone, email, or written correspondence.

Source: National Uniform Claim Committee , 2009 [7/1/2009: new]

Effective Date 10/1/2009

Technician

374700000X Technician

(1) A person with specialized training in a narrow field of expertise whose occupation requires training and is skilled in specific technical processes and procedures. (2) An individual having special skill or practical knowledge in an area, such as operation and maintenance of equipment or performance of laboratory procedures involving biochemical analyses. Special technical qualifications are normally required, though an increasing number or technicians also possess university degrees in science, and occasionally doctorate degrees. The distinction between technician and technologist in the health care field is not always clear.

Sources: (1) Rhea, Ott, and Shafritz, The Facts on File Dictionary of Health Care Management, New York: Facts on File Publications, 1988; Dorland's Illustrated Medical Dictionary, 26th Edition, Philadelphia: W.B. Saunders Company, 1981 and Webster's II New Riverside University Dictionary, Boston: Riverside Publishing Company, 1984. (2)) Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 776.

Effective Date 4/1/2002

Specialization: Attendant Care Provider

3747A0650X Attendant Care Provider

An individual who provides hands-on care, of both a supportive and health related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by state law.

[7/1/2003: new]

Effective Date 10/1/2003

Nursing Service Related Providers

Technician

Specialization: Personal Care Attendant

3747P1801X Personal Care Attendant

An individual who provides assistance with eating, bathing, dressing, personal hygiene, activities of daily living as specified in the plan of care. Services which are incidental to the care furnished, or essential to the health and welfare of the individual may also be provided. Personal care providers must meet state defined training and certification standards

[7/1/2003: definition added]

Effective Date 4/1/2002 Last Modified Date 7/1/2003

Other Service Providers

Acupuncturist

171100000X Acupuncturist

An acupuncturist is a person who performs ancient therapy for alleviation of pain, anesthesia and treatment of some diseases. Acupuncturists use long, fine needles inserted into specific points in order to treat painful conditions or produce anesthesia.

#Type!

Effective Date 4/1/2002

Case Manager/Care Coordinator

171M00000X Case Manager/Care Coordinator

A person who provides case management services and assists an individual in gaining access to needed medical, social, educational, and/or other services. The person has the ability to provide an assessment and review of completed plan of care on a periodic basis. This person is also able to take collaborative action to coordinate the services with other providers and monitor the enrollee's progress toward the cost-effective achievement of objectives specified in the plan of care. Credentials may vary from an experience in the fields of psychology, social work, rehabilitation, nursing or a closely related human service field, to a related Assoc of Arts Degree or to nursing credentials. Some states may require certification in case management.

Source: CMS State Medicaid Manual Section 4442.3 [7/1/2006: new]

Effective Date 10/1/2006

Clinical Ethicist

174V00000X Clinical Ethicist

A clinical ethicist has been trained in bioethics and ethics case consultation. The clinical ethicist addresses medical-ethical dilemmas arising in clinical practice, such as end-of-life care, refusal of treatment, and futility of care; assists patients and health care providers with medical decision-making; and provides ethics education for patients and families.

Source: National Uniform Claim Committee [1/1/2011: new]

Effective Date 4/1/2011

Other Service Providers

Community Health Worker

172V00000X Community Health Worker

Community health workers (CHW) are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve. They have been identified by many titles such as community health advisors, lay health advocates, "promotores(as), outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening. Some examples of these practitioners are Community Health Aides or Practitioners established under 25 USC 1616 (l) under HHS, Indian Health Service, Public Health Service.

Source: Health Resources and Services Administration, US Department of Health and Human Services - National Workforce Study on Community Health Workers, March, 2007. [7/1/2007: new] http://bhpr.hrsa.gov/healthworkforce/chw/

Effective Date 10/1/2007

Contractor

171W00000X Contractor

A person who contracts to supply certain materials or do certain work for a stipulated sum; esp., one whose business is contracting work in any of the building trades. For purposes of the taxonomy, a person who contracts to complete home repairs or modifications to accommodate a health condition (e.g. wheelchair ramp, kitchen counter lowering).

Source: Websters New World Dictionary of the American Language, Second College Edition, William Collins + World Publishing Co., Inc., New York: 1974, p. 308

Effective Date 4/1/2002

Specialization: Home Modifications

171WH0202X Home Modifications Contractor

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Vehicle Modifications

171WV0202X Vehicle Modifications Contractor

A contractor who makes modifications to private vehicles to accommodate a health condition.

#Type!

Effective Date 4/1/2002

Other Service Providers

Driver

172A00000X Driver

A person employed to operate a motor vehicle as a carrier of persons or property.

#Type!

Effective Date 4/1/2002

Funeral Director

176P00000X Funeral Director

A person, usually an embalmer, whose business is to arrange for the burial or cremation of the dead and to assist at the funeral rites.

Source: Joint Commission on Accreditation of Healthcare Organizations, Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, Oakbrook Terrace, IL: 1994, p. 323

Effective Date 4/1/2002

Genetic Counselor, MS

170300000X Genetic Counselor (M.S.)

A masters trained health care provider who collects and interprets genetic family histories; assesses the risk of disease occurrence or recurrence; identifies interventions to manage or ameliorate disease risk; educates about inheritance, testing, management, prevention, ethical issues, resources, and research; and counsels to promote informed choices and adaptation. Certification was established in 1993 by the American Board of Genetic Counseling and prior to that by the American Board of Medical Genetics. Requirements for experience, licensure, and job responsibilities vary among the states.

Source: National Society of Genetic Counselors [7/1/2005: new]

Effective Date 10/1/2005

Health & Wellness Coach

171400000X Health & Wellness Coach

The Health & Wellness Coach is trained in motivational theories, strategies, and communication techniques, which are used to assist patients to develop intrinsic motivation and obtain skills to create sustainable change for improved health and well-being. Health and wellness coaching is a patient-centered approach wherein patients at least partially determine their goals, use self-discovery or active learning processes together with content education to work toward their goals, and self-monitor behaviors to increase accountability, all within the context of an interpersonal relationship with a coach.

Source: National Board for Health & Wellness Coaching, www.nbhwc.org [1/1/2021: new]

Effective Date 4/1/2021

Other Service Providers

Health Educator

174H00000X Health Educator

Health educators work in a variety of settings providing education to individuals or groups of individuals on healthy behaviors, wellness, and health-related topics with the goal of preventing diseases and health problems. Health educators generally require a bachelor's degree and may receive additional training, such as through mentoring, internships, or volunteer work.

Source: National Uniform Claim Committee, 2009 [7/1/2009: new]

Effective Date 10/1/2009

Homeopath

175L00000X Homeopath

A provider who is educated and trained in a system of therapeutics in which diseases are treated by drugs which are capable of producing in healthy persons symptoms like those of the disease to be treated. Treatment requires administering a drug in minute doses.

Source: Dorland's Illustrated Medical Dictionary. 26th edition. Philadelphia: W.B. Saunders Company, 1981.

Effective Date 4/1/2002

Interpreter

171R00000X Interpreter

An Interpreter is a person who translates oral communication between two or more people. This includes translating from one language to another or interpreting sign language. An interpreter is necessary for medical care when the patient does not speak the language of the health care provider or when the patient has a disability involving spoken language.

Source: National Medicaid EDI HIPAA NPI Sub Work Group [7/1/2006: new]

Effective Date 10/1/2006

Lactation Consultant, Non-RN

174N00000X Lactation Consultant (Non-RN)

An individual trained to provide breastfeeding assistance services to both mothers and infants. Lactation Consultants are not required to be nurses and are trained through specific courses of education. The Lactation Consultant may have additional certification through a national or international organization.

Source: National Uniform Claim Committee [1/1/2011: new]

Effective Date 4/1/2011

Other Service Providers

Legal Medicine

173000000X Legal Medicine

The specialty areas of medicine concerned with matters of, and relations with, substantive law and legal institutions; such as the conduct of medical examinations at crime scenes, performance of autopsies, giving of expert medical testimony in judicial proceedings, medical treatment of inmates of penal institutions, the practice of trauma medicine in law enforcement settings, and other clinical practice and medical science applications in the fields of law, law enforcement, and corrections.

Source: Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Mechanotherapist

172M00000X Mechanotherapist

A practitioner of mechanotherapy examines patients by verbal inquiry, examination of the musculoskeletal system by hand, and visual inspection and observation. In the treatment of patients, mechanotherapists employ the techniques of advised or supervised exercise; electrical neuromuscular stimulation; massage or manipulation; or air, water, heat, cold, sound, or infrared ray therapy.

Source: Summarized from Ohio Revised Code 4731.15 [1/1/2007: new]

Effective Date 4/1/2007

Medical Genetics, Ph.D. Medical Genetics

170100000X Ph.D. Medical Genetics

A medical geneticist works in association with a medical specialist, is affiliated with a clinical genetics program, and serves as a consultant to medical and dental specialists.

A general certificate was first issued by ABMS in 1982. ACGME Accredited Residency Program Requirements: None.

Effective Date 4/1/2002

Midwife

176B00000X Midwife

A Midwife is a trained professional with special expertise in supporting women to maintain a healthy pregnancy birth, offering expert individualized care, education, counseling, and support to a woman and her newborn throughout the childbearing cycle. A Midwife is a skilled and independent practitioner who has undergone formalized training. Midwives are not required to be nurses and may be trained via multiple routes of education (apprenticeship, workshop, formal classes, or programs, etc., usually a combination). The educational background requirements and licensing requirements vary by state. The Midwife may or may not be certified by a state or national organization.

Source: The National Uniform Claim Committee [7/1/2007: title changed, definition changed, source changed]

Effective Date 4/1/2002 Last Modified Date 7/1/2007

Other Service Providers

Midwife, Lay

175M00000X Lay Midwife

A person qualified by experience and limited specialized training to provide obstetric and neo-natal care in the management of women having normal pregnancy, labor and childbirth. The lay midwife is licensed in some states.

#Type!

Effective Date 4/1/2002

Military Health Care Provider

171000000X Military Health Care Provider

Active duty military health care providers not otherwise classified who need to be separately identified for operational, clinical, or administrative processes.

[7/1/2005: new]

Effective Date 10/1/2005

Specialization: Independent Duty Corpsman

1710I1002X Independent Duty Corpsman

A Navy Independent Duty Corpsman (IDC) is an active duty Sailor who has successfully completed one of the Navy's specific IDC training programs. IDCs are formally trained and educated to perform primary medical care and minor surgical services in a variety of health care and non-health care settings worldwide under indirect physician supervision. IDCs provide care to Department of Defense operational forces and other supporting forces such as contractors and foreign nationals.

Source: Bureau of Medicine and Surgery, Department of the Navy [7/1/2005: new]

Effective Date 10/1/2005

Specialization: Independent Duty Medical Technicians

1710I1003X Independent Duty Medical Technicians

An Independent Duty Medical Technician (IDMT) is specially trained and educated to perform primary medical care, minor surgical services, and treatment of dental disorders for active duty military members in a variety of health care and non-health care settings worldwide under direct and indirect physician supervision. An IDMT may take medical histories, perform physical exams, order lab tests and x-rays, prescribe medications, and give immunizations. IDMTs work under the direct supervision of a physician preceptor when at home station and indirectly when assigned to a Mobile Aid Station, Mobile Medical Unit, remote site, or otherwise deployed specifically as an IDMT. An IDMT may be an experienced Aerospace Medical Service Technician who meets special task qualifications and is recommended for training by the Aerospace Medical Service Functional Manager at their Medical Treatment Facility. IDMTs maintain certification as Nationally Registered Emergency Medical Technicians and as Immunization Back-up Technicians.

Source: Air Force Surgeon General Office [7/1/2005: new]

Effective Date 10/1/2005

Other Service Providers

Naprapath

172P00000X Naprapath

Naprapathy means a branch of medicine that focuses on the evaluation and treatment of neuron-muscular conditions. Doctors of naprapathy are connective tissue specialists. Education and training are defined through individual states' licensing/certification requirements.

Source: National Uniform Claim Committee [1/1/2007: new]

Effective Date 4/1/2007

Naturopath

175F00000X Naturopath

Diagnoses, treats, and cares for patients, using system of practice that bases treatment of physiological functions and abnormal conditions on natural laws governing human body: Utilizes physiological, psychological, and mechanical methods, such as air, water, light, heat, earth, phototherapy, food and herb therapy, psychotherapy, electrotherapy, physiotherapy, minor and orificial surgery, mechanotherapy, naturopathic corrections and manipulation, and natural methods or modalities, together with natural medicines, natural processed foods, and herbs and nature's remedies. Excludes major surgery, therapeutic use of x ray and radium, and use of drugs, except those assimilable substances containing elements or compounds which are components of body tissues and are physiologically compatible to body processes for maintenance of life.

Source: The Federal Dictionary of Occupational Titles, U.S. Department of Labor, Washington, D.C., section #079, 101-014 [7/1/2007: definition changed, source added]

Effective Date 4/1/2002 Last Modified Date 7/1/2007

Peer Specialist

175T00000X Peer Specialist

Individuals certified to perform peer support services through a training process defined by a government agency, such as the Department of Veterans Affairs or a state mental health department/certification/licensing authority.

Source: National Uniform Claim Committee [7/1/2014: new]

Effective Date 10/1/2014

Prevention Professional

405300000X Prevention Professional

Prevention Professionals work in programs aimed to address specific patient needs, such as suicide prevention, violence prevention, alcohol avoidance, drug avoidance, and tobacco prevention. The goal of the program is to reduce the risk of relapse, injury, or re-injury of the patient. Prevention Professionals work in a variety of settings and provide appropriate case management, mediation, referral, and mentorship services. Individuals complete prevention professionals training for the population of patients with whom they work.

Source: National Uniform Claim Committee, 2015 [1/1/2016: new]

Effective Date 4/1/2016

Other Service Providers

Reflexologist

173C00000X Reflexologist

Reflexologists perform a non-invasive complementary modality involving thumb and finger techniques to apply alternating pressure to the reflexes within the reflex maps of the body located on the feet, hands, and outer ears. Reflexologists apply pressure to specific areas (feet, hands, and ears) to promote a response from an area far removed from the tissue stimulated via the nervous system and acupuncture meridians. Reflexologists are recommended to complete a minimum of 200 hours of education, typically including anatomy & physiology, Reflexology theory, body systems, zones, meridians & relaxation response, ethics, business standards, and supervised practicum.

Source: National Uniform Claim Committee (based on the American Reflexology Certification Board definition of Reflexology), 2007 [1/1/2008: new] Additional Resources: Foot and hand reflexology is a scientific art based on the premise that there are zones and reflex areas in the feet and hands which correspond to all body parts. The physical act of applying specific pressures using thumb, finger and hand techniques result in stress reduction which causes a physiological change in the body. Reflexology is a non-invasive, complementary modality involving thumb and finger techniques to apply alternating pressure to reflexes shown on reflex maps of the body located on the feet, hands, and outer ears. American Reflexology Certification Board, www.arcb.net/definiti.htm; Reflexology Association of America, www.reflexology-usa.org/standards.html

Effective Date 4/1/2008

Sleep Specialist, PhD

173F00000X Sleep Specialist (PhD)

Sleep medicine is a clinical specialty with a focus on clinical problems that require accurate diagnosis and treatment. The knowledge base of sleep medicine is derived from many disciplines including neuroanatomy, neurophysiology, respiratory physiology, pharmacology, psychology, psychiatry, neurology, general internal medicine, pulmonary medicine, and pediatrics as well as others.

Source: National Uniform Claim Committee (based on American Board of Sleep Medicine), 2007 [1/1/2008: new] Additional resources: www.absm.org

Effective Date 4/1/2008

Specialist

174400000X Specialist

An individual educated and trained in an applied knowledge discipline used in the performance of work at a level requiring knowledge and skills beyond or apart from that provided by a general education or liberal arts degree.

Source: Expanded from Webster's II New Riverside University Dictionary, Boston: Riverside Publishing Company, 1974.

Effective Date 4/1/2002

Other Service Providers

Specialist

Specialization: Graphics Designer
1744G0900X **Graphics Designer**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Prosthetics Case Management
1744P3200X **Prosthetics Case Management**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Research Data Abstracter/Coder
1744R1103X **Research Study Abstracter/Coder**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Research Study
1744R1102X **Research Study Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Veterinarian

174M00000X **Veterinarian**

A doctor of veterinary medicine, trained and authorized to practice veterinarian medicine and surgery.

Source: Dorland's Illustrated Medical Dictionary. 28th edition. Philadelphia: W.B. Saunders Company, 1994, p. 1823

Effective Date 4/1/2002

Specialization: Medical Research
174MM1900X **Medical Research Veterinarian**

Definition to come...

#Type!

Effective Date 4/1/2002

Pharmacy Service Providers

Pharmacist

183500000X Pharmacist

An individual licensed by the appropriate state regulatory agency to engage in the practice of pharmacy. The practice of pharmacy includes, but is not limited to, assessment, interpretation, evaluation, and implementation, initiation, monitoring or modification of medication and or medical orders; the compounding or dispensing of medication and or medical orders; participation in drug and device procurement, storage, and selection; drug administration; drug regimen reviews; drug or drug-related research; provision of patient education and the provision of those acts or services necessary to provide medication therapy management services in all areas of patient care.

Source: Adapted from National Association of Boards of Pharmacy Model State Pharmacy Act, Article 1, Section 104. [1/1/2006: definition modified, source modified]

Effective Date 4/1/2002 Last Modified Date 1/1/2006

Specialization: Ambulatory Care

1835P2201X Ambulatory Care Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill in the provision of integrated, accessible health care services by pharmacists and is accountable for addressing medication needs, developing sustained partnerships with patients, and practicing in the context of family and community.

Source: Board of Pharmacy Specialties, www.bpsweb.org [7/1/2015: new]

Effective Date 10/1/2015

Specialization: Cardiology

1835C0206X Cardiology Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill in direct patient care to ensure safe and effective use of medications in patients with cardiovascular disease, as members of interprofessional health care teams.

Source: Board of Pharmacy Specialties, www.bpsweb.org

Effective Date 4/1/2023

Specialization: Compounded Sterile Preparations

1835C0207X Compounded Sterile Preparations Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill to ensure that sterile preparations meet the clinical needs of patients, satisfying quality, safety, and environmental control requirements, regulations, and standards in all phases of preparation, storage, transportation, and administration.

Source: Board of Pharmacy Specialties, www.bpsweb.org

Effective Date 4/1/2023

Specialization: Critical Care

1835C0205X Critical Care Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill in the delivery of patient care services by pharmacists, as integral members of interprofessional teams, working to ensure the safe and effective use of medications in critically ill patients.

Source: Board of Pharmacy Specialties, www.bpsweb.org [1/1/2016: new]

Effective Date 4/1/2016

Pharmacy Service Providers

Pharmacist

Specialization: Emergency Medicine

1835E0208X **Emergency Medicine Pharmacist**

A licensed pharmacist who has demonstrated specialized knowledge and skill in the care for patients at the bedside in emergency medicine settings.

Source: Board of Pharmacy Specialties, www.bpsweb.org

Effective Date 4/1/2023

Specialization: General Practice

1835G0000X **Deactivated - Pharmacist**

[1/1/2006: marked inactive, use value 183500000X]

Effective Date 4/1/2002 Deactivation Date 3/31/2006

Specialization: Geriatric

1835G0303X **Geriatric Pharmacist**

A pharmacist who is certified in geriatric pharmacy practice is designated as a "Certified Geriatric Pharmacist" (CGP). To become certified, candidates are expected to be knowledgeable about principles of geriatric pharmacotherapy and the provision of pharmaceutical care to the elderly.

Source: Commission for Certification in Geriatric Pharmacy (www.ccgp.org) [7/1/2006: new]

Effective Date 10/1/2006

Specialization: Infectious Diseases

1835I0206X **Infectious Diseases Pharmacist**

A licensed pharmacist who has demonstrated specialized knowledge and skill in the use of microbiology and pharmacology to develop, implement, and monitor drug regimens that incorporate antimicrobials to optimize therapy for patients.

Source: Board of Pharmacy Specialties, www.bpsweb.org

Effective Date 4/1/2023

Specialization: Nuclear

1835N0905X **Nuclear Pharmacist**

A licensed pharmacist who has demonstrated specialized knowledge and skill in procurement, compounding, quality control testing, dispensing, distribution, and monitoring of radiopharmaceuticals.

Source: Specialty certification and recertification program administered by Board of Pharmaceutical Specialties, www.bpsweb.org [7/1/2006: modified title, added definition]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Pharmacy Service Providers

Pharmacist

Specialization: Nutrition Support

1835N1003X Nutrition Support Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill in maintenance and/or restoration of optimal nutritional status, designing and modifying treatment according to patient needs.

Source: Specialty certification and recertification program administered by Board of Pharmaceutical Specialties, www.bpsweb.org [7/1/2006: definition modified]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Specialization: Oncology

1835X0200X Oncology Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill in developing, recommending, implementing, monitoring, and modifying pharmacotherapeutic plans to optimize outcomes in patients with malignant diseases.

Source: Specialty certification and recertification program administered by Board of Pharmaceutical Specialties, www.bpsweb.org [7/1/2006: new]

Effective Date 10/1/2006

Specialization: Pediatrics

1835P0200X Pediatric Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill in the delivery of patient care services by pharmacists that ensures the safe and effective use of medications for all children from neonates through adolescents.

Source: Board of Pharmacy Specialties, www.bpsweb.org [1/1/2016: new]

Effective Date 4/1/2016

Specialization: Pharmacist Clinician (PhC)/ Clinical Pharmacy Specialist

1835P0018X Pharmacist Clinician (PhC)/ Clinical Pharmacy Specialist

Pharmacist Clinician/Clinical Pharmacy Specialist is a pharmacist with additional training and an expanded scope of practice that may include prescriptive authority, therapeutic management, and disease management.

Source: National Uniform Claim Committee, 2007 [1/1/2008: new]

Effective Date 4/1/2008

Specialization: Pharmacotherapy

1835P1200X Pharmacotherapy Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill in optimizing pharmacotherapeutic care of patients, by developing, implementing, monitoring, and modifying complex treatment plans, providing advanced level education and consultation, and collaborating with other health professionals in the management of therapy.

Source: Specialty certification and recertification program administered by Board of Pharmaceutical Specialties, www.bpsweb.org [7/1/2006: modified definition]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Pharmacy Service Providers

Pharmacist

Specialization: Psychiatric

1835P1300X Psychiatric Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill in optimizing care of patients with psychiatric illness by assessing and monitoring patients, recognizing drug-induced problems, and recommending appropriate treatment plans.

Source: Specialty certification and recertification program administered by Board of Pharmaceutical Specialties, www.bpsweb.org [7/1/2006: modified title, added definition]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Specialization: Solid Organ Transplant

1835S0206X Solid Organ Transplant Pharmacist

A licensed pharmacist who has demonstrated specialized knowledge and skill delivering direct patient care and the safe and effective use of medications for patients in all phases of solid organ transplantation.

Source: Board of Pharmacy Specialties, www.bpsweb.org

Effective Date 4/1/2023

Pharmacy Technician

183700000X Pharmacy Technician

A person who works under the direct supervision of a licensed pharmacist and performs many pharmacy-related functions that do not require the professional judgment of a pharmacist.

Source: Pharmacy Technician Certification Board, www.ptcb.org [1/1/2006: modified definition, modified source]

Effective Date 4/1/2002 Last Modified Date 1/1/2006

Physician Assistants & Advanced Practice Nursing Providers

Advanced Practice Midwife

367A00000X Advanced Practice Midwife

Advanced practice midwifery encompasses the independent provision of care during pregnancy, childbirth, and the postpartum period; sexual and reproductive health; gynecologic health; and family planning services, including preconception care. Midwives also provide primary care for individuals from adolescence throughout the lifespan as well as care for the healthy newborn during the first 28 days of life. Midwives provide initial and ongoing comprehensive assessment, diagnosis, and treatment. Midwifery care includes health promotion, disease prevention, risk assessment and management, and individualized wellness education and counseling.

Source: American College of Nurse-Midwives, www.midwife.org
Additional Resources: See the American College of Nurse-Midwives, www.midwife.org, for more information on Certified Nurse-Midwives, Certified Midwives, the American Midwifery Certification Board (AMCB), and licensure.

Effective Date 4/1/2002 Last Modified Date 1/1/2023

Physician Assistants & Advanced Practice Nursing Providers

Anesthesiologist Assistant

367H00000X Anesthesiologist Assistant

An individual certified by the state to perform anesthesia services under the direct supervision of an anesthesiologist. Anesthesiologist Assistants are required to have a bachelor's degree with a premed curriculum prior to entering a two-year anesthesiology assistant program, which is focused upon the delivery and maintenance of anesthesia care as well as advanced patient monitoring techniques. An Anesthesiologist Assistant must work as a member of the anesthesia care team under the direction of a qualified Anesthesiologist.

#Type!

Effective Date 4/1/2002

Clinical Nurse Specialist

364S00000X Clinical Nurse Specialist

A registered nurse who, through a graduate degree program in nursing, or through a formal post-basic education program or continuing education courses and clinical experience, is expert in a specialty area of nursing practice within one or more of the components of direct patient/client care, consultation, education, research and administration.

Sources: American Nurses Association, American Nurses Credentialing Center, 1996 Certification Catalogue and The Interagency Conference on Nursing Statistics.

Effective Date 4/1/2002

Specialization: Acute Care

364SA2100X Acute Care Clinical Nurse Specialist

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Adult Health

364SA2200X Adult Health Clinical Nurse Specialist

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Chronic Care

364SC2300X Chronic Care Clinical Nurse Specialist

Definition to come...

#Type!

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Clinical Nurse Specialist

Specialization: Community Health/Public Health

364SC1501X **Community Health/Public Health Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Critical Care Medicine

364SC0200X **Critical Care Medicine Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Emergency

364SE0003X **Emergency Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Ethics

364SE1400X **Ethics Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Family Health

364SF0001X **Family Health Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Gerontology

364SG0600X **Gerontology Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Clinical Nurse Specialist

Specialization: Holistic

364SH1100X **Holistic Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Home Health

364SH0200X **Home Health Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Informatics

364SI0800X **Informatics Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Long-Term Care

364SL0600X **Long-Term Care Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Medical-Surgical

364SM0705X **Medical-Surgical Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Neonatal

364SN0000X **Neonatal Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Clinical Nurse Specialist

Specialization: Neuroscience

364SN0800X **Neuroscience Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Occupational Health

364SX0106X **Occupational Health Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Oncology

364SX0200X **Oncology Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Oncology, Pediatrics

364SX0204X **Pediatric Oncology Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Pediatrics

364SP0200X **Pediatric Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Perinatal

364SP1700X **Perinatal Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Clinical Nurse Specialist

Specialization: Perioperative

364SP2800X **Perioperative Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health

364SP0808X **Psychiatric/Mental Health Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health, Adult

364SP0809X **Adult Psychiatric/Mental Health Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health, Child & Adolescent

364SP0807X **Child & Adolescent Psychiatric/Mental Health Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health, Child & Family

364SP0810X **Child & Family Psychiatric/Mental Health Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health, Chronically Ill

364SP0811X **Chronically Ill Psychiatric/Mental Health Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Clinical Nurse Specialist

Specialization: Psychiatric/Mental Health, Community

364SP0812X **Community Psychiatric/Mental Health Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Psychiatric/Mental Health, Geropsychiatric

364SP0813X **Geropsychiatric Psychiatric/Mental Health Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Rehabilitation

364SR0400X **Rehabilitation Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: School

364SS0200X **School Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Transplantation

364ST0500X **Transplantation Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Women's Health

364SW0102X **Women's Health Clinical Nurse Specialist**

Definition to come...

#Type!

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Nurse Anesthetist, Certified Registered

367500000X Certified Registered Nurse Anesthetist

(1) A licensed registered nurse with advanced specialty education in anesthesia who, in collaboration with appropriate health care professionals, provides preoperative, intraoperative, and postoperative care to patients and assists in management and resuscitation of critical patients in intensive care, coronary care, and emergency situations. Nurse anesthetists are certified following successful completion of credentials and state licensure review and a national examination directed by the Council on Certification of Nurse Anesthetists. (2) A registered nurse who is qualified by special training to administer anesthesia in collaboration with a physician or dentist and who can assist in the care of patients who are in critical condition.

Sources: (1) Council on Certification of Nurse Anesthetists, Park Ridge, IL, and Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988. (2) Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 548.

Effective Date 4/1/2002

Nurse Practitioner

363L00000X Nurse Practitioner

(1) A registered nurse provider with a graduate degree in nursing prepared for advanced practice involving independent and interdependent decision making and direct accountability for clinical judgment across the health care continuum or in a certified specialty. (2) A registered nurse who has completed additional training beyond basic nursing education and who provides primary health care services in accordance with state nurse practice laws or statutes. Tasks performed by nurse practitioners vary with practice requirements mandated by geographic, political, economic, and social factors. Nurse practitioner specialists include, but are not limited to, family nurse practitioners, gerontological nurse practitioners, pediatric nurse practitioners, obstetric-gynecologic nurse practitioners, and school nurse practitioners.

Source: (1) American Nurses' Association, American Nurses Credentialing Center, 1996 Certification Catalogue. (2)) Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 549.

Effective Date 4/1/2002

Specialization: Acute Care

363LA2100X Acute Care Nurse Practitioner

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Adult Health

363LA2200X Adult Health Nurse Practitioner

Definition to come...

#Type!

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Nurse Practitioner

Specialization: Community Health
363LC1500X **Community Health Nurse Practitioner**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Critical Care Medicine
363LC0200X **Critical Care Medicine Nurse Practitioner**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Family
363LF0000X **Family Nurse Practitioner**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Gerontology
363LG0600X **Gerontology Nurse Practitioner**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Neonatal
363LN0000X **Neonatal Nurse Practitioner**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Neonatal, Critical Care
363LN0005X **Critical Care Neonatal Nurse Practitioner**

Definition to come...

#Type!

Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Nurse Practitioner

Specialization: Obstetrics & Gynecology
363LX0001X **Obstetrics & Gynecology Nurse Practitioner**
Definition to come...
#Type!
Effective Date 4/1/2002

Specialization: Occupational Health
363LX0106X **Occupational Health Nurse Practitioner**
Definition to come...
#Type!
Effective Date 4/1/2002

Specialization: Pediatrics
363LP0200X **Pediatric Nurse Practitioner**
Definition to come...
#Type!
Effective Date 4/1/2002

Specialization: Pediatrics, Critical Care
363LP0222X **Critical Care Pediatric Nurse Practitioner**
Definition to come...
#Type!
Effective Date 4/1/2002

Specialization: Perinatal
363LP1700X **Perinatal Nurse Practitioner**
Definition to come...
#Type!
Effective Date 4/1/2002

Specialization: Primary Care
363LP2300X **Primary Care Nurse Practitioner**
Definition to come...
#Type!
Effective Date 4/1/2002

Physician Assistants & Advanced Practice Nursing Providers

Nurse Practitioner

Specialization: Psychiatric/Mental Health

363LP0808X **Psychiatric/Mental Health Nurse Practitioner**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: School

363LS0200X **School Nurse Practitioner**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Women's Health

363LW0102X **Women's Health Nurse Practitioner**

Definition to come...

#Type!

Effective Date 4/1/2002

Physician Assistant

363A00000X **Physician Assistant**

A physician assistant is a person who has successfully completed an accredited education program for physician assistant, is licensed by the state and is practicing within the scope of that license. Physician assistants are formally trained to perform many of the routine, time-consuming tasks a physician can do. In some states, they may prescribe medications. They take medical histories, perform physical exams, order lab tests and x-rays, and give inoculations. Most states require that they work under the supervision of a physician.

#Type!

Effective Date 4/1/2002

Specialization: Medical

363AM0700X **Medical Physician Assistant**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Surgical

363AS0400X **Surgical Physician Assistant**

Definition to come...

#Type!

Effective Date 4/1/2002

Podiatric Medicine & Surgery Service Providers

Assistant, Podiatric

211D00000X Podiatric Assistant

An individual who assists a podiatrist in tasks, such as exposing and developing x-rays; taking and recording patient histories; assisting in biomechanical evaluations and negative castings; preparing and sterilizing instruments and equipment; providing the patient with postoperative instructions; applying surgical dressings; preparing the patient for treatment, padding, and strapping; and performing routine office procedures.

Source: (1) Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 622.

Effective Date 4/1/2002

Podiatrist

213E00000X Podiatrist

A podiatrist is a person qualified by a Doctor of Podiatric Medicine (D.P.M.) degree, licensed by the state, and practicing within the scope of that license. Podiatrists diagnose and treat foot diseases and deformities. They perform medical, surgical and other operative procedures, prescribe corrective devices and prescribe and administer drugs and physical therapy.

#Type!

Effective Date 4/1/2002

Specialization: Foot & Ankle Surgery

213ES0103X Foot & Ankle Surgery Podiatrist

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Foot Surgery

213ES0131X Foot Surgery Podiatrist

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: General Practice

213EG0000X Deactivated - Podiatrist

[7/1/2006: marked inactive, use value 213E00000X]

Effective Date 4/1/2002 Deactivation Date 9/30/2006

Podiatric Medicine & Surgery Service Providers

Podiatrist

Specialization: Primary Podiatric Medicine

213EP1101X **Primary Podiatric Medicine Podiatrist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Public Medicine

213EP0504X **Public Medicine Podiatrist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Radiology

213ER0200X **Radiology Podiatrist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Sports Medicine

213ES0000X **Sports Medicine Podiatrist**

Definition to come...

#Type!

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Anaplastologist

229N00000X **Anaplastologist**

An anaplastologist is a professional who creates prostheses for the face and body. Patients treated include those missing anatomy due to cancer, traumatic injury, or birth differences. Generally, there are no state licensing requirements for anaplastologists. Certification specific to anaplastology is provided through the Board for Certified Clinical Anaplastology (BCCA) with a credential title of Certified Clinical Anaplastologist (CCA).

Source: American Anaplastology Association, www.anaplastology.org. [7/1/2006: new]

Effective Date 10/1/2006

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Art Therapist

221700000X Art Therapist

(1) An individual who uses art to achieve the therapeutic goals of symptom relief, emotional integration, and recovery from or adjustment to illness or disability. (2) An art therapist uses a form of treatment that enables patients with mental or physical disabilities to use art as a way of expressing and dealing with feelings and inner conflicts. (3) An individual who uses arts modalities and creative processes during intentional intervention in therapeutic, rehabilitative, community, or educational settings to foster health, communication, and expression; promote the integration of physical, emotional, cognitive, and social functioning; enhance self-awareness; and facilitate change.

Source: (1) Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 107. (2) Art Therapy Program, Marymount College, Tarrytown, NY (3) National Coalition of Arts

Effective Date 4/1/2002

Clinical Exercise Physiologist

224Y00000X Clinical Exercise Physiologist

A Clinical Exercise Physiologist is a health care professional who is trained to work with patients with chronic disease where exercise training has been shown to be of therapeutic benefit, including but not limited to cardiovascular and pulmonary disease, and metabolic disorders.

Source: What is a Clinical Exercise Physiologist? Clinical Exercise Physiology Association (CEPA), CEPA Executive Board, 2008 [10/1/2011: new]

Effective Date 10/1/2011

Dance Therapist

225600000X Dance Therapist

The dance therapist, sometimes called a movement therapist, focuses on rhythmic body movements as a medium of physical and psychological change. Dance therapy is practiced more often with mental health patients than with physically disabled patients. A master's degree is required by the American Dance Therapy Association to award the credentials Dance Therapist Registered (DTR).

Source: Joel A. DeLisa and Bruce M. Gans, Rehabilitation Medicine: Principles and Practice Second Edition, J.B. Lippincott Company, Philadelphia: 1993, p. 11

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Developmental Therapist

222Q00000X Developmental Therapist

A Developmental Therapist is a person qualified by completion of an approved program in Developmental Therapy and where applicable credentialed by the state and practicing within the scope of the credential, or credentialed by completion of education experiences as approved by the state and practicing within the scope of that credential or, where state credentialing does not exist, certified by the Board of the Developmental Therapy Association. A developmental therapist evaluates children's global development in order to identify areas of developmental delay whether arising from physiological, neurological, or environmental factors, or a combination of factors; and designs, implements, and modifies therapeutic interventions for the child and the family to promote the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction in order to maximize functional independence and developmental homeostasis, and improve the quality of life at home and in the community; and provides consultation for the parents and other professionals working with the family on global development.

Source: The Illinois Developmental Therapists Association [1/1/2007: new]

Effective Date 4/1/2007

Kinesiotherapist

226300000X Kinesiotherapist

A provider trained and educated in the applied science of medically prescribed therapeutic exercise, education and adapted physical activities designed to improve the quality of line and health of adults and children by developing physical fitness, increasing mobility and independence, and improving psychosocial behavior. The kinesiotherapist seeks a coach-player relationship in which he/she helps the patient/client reach the goal of becoming an independent, self-sustaining person. Kinesiotherapists, as compared with physical therapists, put more emphasis on geriatric care, reconditioning and fitness, and psychiatric care. A large percentage of kinesiotherapists practice in Veterans Administration hospitals.

Source: The Kinesiotherapy Association.

Effective Date 4/1/2002

Massage Therapist

225700000X Massage Therapist

An individual trained in the manipulation of tissues (as by rubbing, stroking, kneading, or tapping) with the hand or an instrument for remedial or hygienic purposes.

#Type!

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Mastectomy Fitter

224900000X Mastectomy Fitter

An individual trained in the fitting and adjusting of breast prostheses and management of post-mastectomy prostheses services.

Source: National Uniform Claim Committee [7/1/2010: new] Additional Resources: American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc., www.abcop.org and Board of Certification/Accreditation, International, www.bocusa.org.

Effective Date 10/1/2010

Music Therapist

225A00000X Music Therapist

Music therapists use music interventions to assess clients' strengths and needs, develop goals, implement services, and evaluate and document progress for individuals of all ages. Music therapists facilitate changes in physical, cognitive, emotional, and/or psychosocial health.

Source: American Music Therapy Association

Effective Date 4/1/2002

Occupational Therapist

225X00000X Occupational Therapist

An occupational therapist is a person who has graduated from an entry-level occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) or predecessor organizations, or approved by the World Federation of Occupational Therapists (WFOT), or an equivalent international occupational therapy education program; has successfully completed a period of supervised fieldwork experience required by the occupational therapy program; has passed a nationally recognized entry-level examination for occupational therapists, and fulfills state requirements for licensure, certification, or registration. An occupational therapist provides interventions based on evaluation and which emphasize the therapeutic use of everyday life activities (i.e., occupations) with individuals or groups for the purpose of facilitating participation in roles and situations and in home, school, workplace, community and other settings. Occupational therapy services are provided for the purpose of promoting health and wellness and are provided to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapists address the physical, cognitive, psychosocial, sensory, and other aspects of occupational performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: definition changed, added source]

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Occupational Therapist

Specialization: Driving and Community Mobility

225XR0403X Driving and Community Mobility Occupational Therapist

Occupational therapists can optimize and prolong an older driver's ability to drive safely and ease the transition to other forms of transportation if driving cessation becomes necessary. By identifying strengths as well as physical or cognitive challenges, occupational therapists can evaluate an individual's overall ability to operate a vehicle safely and recommend assistive devices or behavioral changes to limit risks. Occupational therapy practitioners offer a continuum of services related to community mobility, from evaluation of driving performance, through counseling and support for lifestyle changes, to maintaining independence and quality of life.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: title changed, definition added, source added] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary specialty certification for a Driving & Community Mobility Occupational Therapist if the applicant meets the following requirements: <ul> Professional or technical degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 2,000 hours of experience as an occupational therapist or occupational therapy assistant. 600 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 3 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Fact Sheets: Older Driver

Effective Date 4/1/2002

Specialization: Environmental Modification

225XE0001X Environmental Modification Occupational Therapist

Occupational therapy practitioners are experts at identifying the cause of difficulties in performance of activities of daily living and instrumental activities of daily living. Occupational therapy practitioners evaluate the client, their environment, and their occupational performance in that environment, as well as make recommendations for products to improve the fit between the client, place, and activity. Occupational therapists can evaluate both the skills of the client and the environmental features that support or limit the performance of meaningful or necessary activities, thereby enhancing health, safety and well-being. Based on this assessment, they recommend modification and intervention strategies that improve the fit between the person and his or her environment.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary specialty certification for an Environmental Modification Occupational Therapist if the applicant meets the following requirements: <ul> Professional or technical degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 2,000 hours of experience as an occupational therapist or occupational therapy assistant. 600 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 3 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Fact Sheets: Home Modifications

Effective Date 10/1/2008

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Occupational Therapist

Specialization: Ergonomics

225XE1200X **Ergonomics Occupational Therapist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Feeding, Eating & Swallowing

225XF0002X **Feeding, Eating & Swallowing Occupational Therapist**

Occupational therapists provide interventions to clients of all ages with feeding, eating and swallowing difficulties. Occupational therapists provide comprehensive rehabilitative, habilitative, and palliative dysphagia care, which includes collaborating with clients to provide individualized compensatory swallowing strategies, modified diet textures, adapted mealtime environments, enhanced feeding skills, preparatory exercises and positioning to clients, reinforcement of mealtime strategies to enhance and improve swallowing skills, and training to caregivers to enhance eating and feeding performance. Occupational therapists provide screening and in-depth clinical assessment which may include instrumental dysphagia assessments including videofluroscopy.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary specialty certification for a Feeding, Eating & Swallowing Occupational Therapist if the applicant meets the following requirements: <ul> Professional or technical degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 2,000 hours of experience as an occupational therapist or occupational therapy assistant. 600 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 3 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Specialized Knowledge and Skills Paper: Feeding, Eating and Swallowing in Occupational Therapy Practice, 2007; AOTA Fact Sheets: OT: A Vital Role in Dysphagia Care

Effective Date 10/1/2008

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Occupational Therapist

Specialization: Gerontology

225XG0600X Gerontology Occupational Therapist

Occupational therapists work with older adults in virtually every setting: assisted living, wellness programs, hospitals, nursing homes, senior centers, clinics and in the home. Occupational therapists bring an understanding of the importance of participation and occupation for overall well-being to those who are experiencing disabling conditions related to aging. The primary overarching goal of occupational therapy services with this population is to maximize independence and participation, thereby enabling an older person to continue to live successfully in his or her chosen environment. Occupational therapists can help older adults by developing strategies to help or maintain safety and well-being, to assist with life transitions, and to compensate for challenges they experience in activities of daily living, instrumental activities of daily living, leisure participation, social participation, and productive activities.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary board certification for a Gerontology Occupational Therapist if the applicant meets the following requirements: <ul> Professional degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 5 years of practice as an occupational therapist. Minimum of 5,000 hours of experience as an occupational therapist in the certification area in the last 7 calendar years. Minimum of 500 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 5 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Fact Sheets: Senior Center and Assisted Living Facilities

Effective Date 10/1/2008

Specialization: Hand

225XH1200X Hand Occupational Therapist

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Human Factors

225XH1300X Human Factors Occupational Therapist

Definition to come...

#Type!

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Occupational Therapist

Specialization: Low Vision

225XL0004X Low Vision Occupational Therapist

Occupational therapists enable children and adults with visual impairment to engage in their chosen daily living activities safely and as independently as possible. This is accomplished by 1) teaching the person to use their remaining vision as efficiently as possible to complete activities; (2) modifying activities so that they can be completed with less vision; (3) training the person in use of adaptive equipment to compensate for vision loss, including high and low technology assistive devices; and (4) modifying the person's environment.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary specialty certification for a Low Vision Occupational Therapist if the applicant meets the following requirements: <ul> Professional or technical degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 2,000 hours of experience as an occupational therapist or occupational therapy assistant. 600 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 3 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Fact Sheets: Low Vision; OT Services for Individuals with Visual Impairments

Effective Date 10/1/2008

Specialization: Mental Health

225XM0800X Mental Health Occupational Therapist

Occupational therapists provide treatment for people recovering from a mental or physical illness to regain their independence and stability and to engage in normal daily occupations (work, home, family life, school, leisure). Occupational therapists provide particular emphasis on interventions that result in improved quality of life and decrease hospitalization.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary board certification for a Mental Health Occupational Therapist if the applicant meets the following requirements: <ul> Professional degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 5 years of practice as an occupational therapist. Minimum of 5,000 hours of experience as an occupational therapist in the certification area in the last 7 calendar years. Minimum of 500 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 5 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Fact Sheets: Partial Hospitalization Programs and Consumer

Effective Date 10/1/2008

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Occupational Therapist

Specialization: Neurorehabilitation

225XN1300X **Neurorehabilitation Occupational Therapist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Pediatrics

225XP0200X **Pediatric Occupational Therapist**

Occupational therapists provide services to infants, toddlers and children who have or who are at risk for developmental delays or disabilities. Occupational therapy is concerned with a child's ability to participate in daily life activities or "occupations." Occupational therapists use their unique expertise to help children with social-emotional, physical, cognitive, communication, and adaptive behavioral challenges and to help children to be prepared for and perform important learning and school-related activities and to fulfill their rule as students. Through an understanding of the impact of disability, illness, and impairment on a child's development, plan, ability to learn new skills, and overall occupational performance, occupational therapists design interventions that promote healthy development, establish needed skills, and/or modify environments, all in support of participation in daily activities.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary board certification for a Pediatric Occupational Therapist if the applicant meets the following requirements: <ul> Professional degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 5 years of practice as an occupational therapist. Minimum of 5,000 hours of experience as an occupational therapist in the certification area in the last 7 calendar years. Minimum of 500 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 5 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Specialized Knowledge and Skills Paper: Occupational Therapy Practice in the Neonatal Intensive Care Unity (2006); AOTA Fact Sheets: Children and the Tsunami, OT for Children Birth to 3 Years of Age, OT's Role with Autism, OT in Educational Settings Under the Individuals with Disabilities Education Act, Transforming Caseload to Workload in School Based and Early Intervention OT Services, OT in Preschool Settings.

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Occupational Therapist

Specialization: Physical Rehabilitation

225XP0019X Physical Rehabilitation Occupational Therapist

Occupational therapists are experts at helping people lead as independent a life as possible. Occupational therapists bring an understanding of the physical and psychological implications of illness and injury and their effects on peoples' ability to perform the tasks of daily living. Occupational therapists provide interventions that can aide a person in completing ADL and IADL tasks, such as dressing, bathing, preparing meals, and driving. They also may fabricate custom orthotics to improve function, evaluate the environment for safety hazards and recommend adaptations to remove those hazards, help a person compensate for cognitive changes, and build a persons' physical endurance and strength. Occupational therapists' knowledge of adapting tasks and modifying the environment to compensate for functional limitations is used to increase the involvement of clients and to promote safety and success.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary board certification for a Physical Rehabilitation Occupational Therapist if the applicant meets the following requirements: <ul> Professional degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 5 years of practice as an occupational therapist. Minimum of 5,000 hours of experience as an occupational therapist in the certification area in the last 7 calendar years. Minimum of 500 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 5 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Consumer Tip Sheets: Stroke, Hip

Effective Date 10/1/2008

Occupational Therapy Assistant

224Z00000X Occupational Therapy Assistant

An occupational therapy assistant is a person who has graduated from an occupational therapy assistant program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) or predecessor organizations, has successfully completed a period of supervised fieldwork experience required by the accredited occupational therapy assistant program, has passed a nationally recognized entry-level examination for occupational therapy assistants, and fulfills state requirements for licensure, certification, or registration. An occupational therapy assistant provides interventions under the supervision of an occupational therapist which emphasize the therapeutic use of everyday life activities (i.e., occupations) with individuals or groups for the purpose of facilitating participation in roles and situations and in home, school, workplace, community and other settings. Occupational therapy services are provided for the purpose of promoting health and wellness and are provided to those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. Occupational therapy assistants address the physical, cognitive, psychosocial, sensory, and other aspects of occupational performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: definition changed, source changed]

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Occupational Therapy Assistant

Specialization: Driving and Community Mobility

224ZR0403X **Driving and Community Mobility Occupational Therapy Assistant**

Occupational therapy assistants contribute to the completion of an individualized occupational therapy driving and community mobility evaluation by administering delegated assessments and identifying findings that impact the client's occupational performance. Clients engage in the assessment and occupational profile process to customize the evaluation to their individual driving and community mobility needs. Occupational therapy assistants administer and continuously modify individualized in-vehicle and community mobility assessments within the naturalistic context of the community in response to the occupational performance and safety behaviors of the client. They also implement an individualized intervention plan, within the parameters established in collaboration with the occupational therapist that reflects the contexts of the client and meets his or her occupational performance and safety needs. Occupational therapy assistants address immediate and long-term implications of psychosocial issues related to compromised driving and community mobility throughout the occupational therapy process and makes recommendations to the occupational therapist for modification to service delivery.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary specialty certification for a Driving & Community Mobility Occupational Therapy Assistant if the applicant meets the following requirements: <ul> Professional or technical degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 2,000 hours of experience as an occupational therapist or occupational therapy assistant. 600 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 3 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Fact Sheets: Older Driver; AOTA Website: Specialty Certification

Effective Date 10/1/2008

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Occupational Therapy Assistant

Specialization: Environmental Modification

224ZE0001X Environmental Modification Occupational Therapy Assistant

Occupational therapy assistants provide environmental modifications under the supervision of an occupational therapist. OTAs develop and implement an individualized occupational therapy environmental modification plan that reflects the relevant contexts of the client and relevant others and maximizes current and future occupational performance, safety, and participation of the client. Clients receive environmental modification recommendations and interventions that enable them to meet occupational performance and participation goals and that have adequate flexibility to accommodate for their future needs.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary specialty certification for an Environmental Modification Occupational Therapy Assistant if the applicant meets the following requirements: <ul> Professional or technical degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 2,000 hours of experience as an occupational therapist or occupational therapy assistant. 600 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 3 calendar years. Service delivery may be paid or voluntary. Verification of employment. Fact Sheet: Home Modifications and OT, AOTA Website: Specialty Certifications

Effective Date 10/1/2008

Specialization: Feeding, Eating & Swallowing

224ZF0002X Feeding, Eating & Swallowing Occupational Therapy Assistant

Occupational therapy assistants provide environmental modifications under the supervision of an occupational therapist. OTAs develop and implement an individualized occupational therapy environmental modification plan that reflects the relevant contexts of the client and relevant others and maximizes current and future occupational performance, safety, and participation of the client. Clients receive environmental modification recommendations and interventions that enable them to meet occupational performance and participation goals and that have adequate flexibility to accommodate for their future needs.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary specialty certification for a Feeding, Eating & Swallowing Occupational Therapy Assistant if the applicant meets the following requirements: <ul> Professional or technical degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 2,000 hours of experience as an occupational therapist or occupational therapy assistant. 600 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 3 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Website: Specialty Certifications; AOTA Specialized Knowledge and Skills Paper: Feeding, Eating and Swallowing in Occupational Therapy Practice, 2007; AOTA Fact Sheets: OT: A Vital Role in Dysphagia Care

Effective Date 10/1/2008

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Occupational Therapy Assistant

Specialization: Low Vision

224ZL0004X Low Vision Occupational Therapy Assistant

Occupational therapy assistants contribute to the completion of an individualized occupational therapy low-vision evaluation under the direction and supervision of the occupational therapist to identify factors that may facilitate, compensate for, or inhibit use of vision in occupational performance. Clients are engaged in the identification of strengths, limitations, and goals as they relate to low vision to optimize independence and participation in desired occupations. Occupational therapy assistants also contribute to the development and implementation of an individualized occupational therapy low-vision intervention plan in collaboration with the occupational therapist, client, and relevant others that reflects the client's priorities for occupational performance.

Source: The Guide to Occupational Therapy Practice, 2nd edition. Bethesda: American Occupational Therapy Association, 2007. [7/1/2008: new] Additional Resources: The American Occupational Therapy Association (AOTA) does offer voluntary specialty certification for a Low Vision Occupational Therapy Assistant if the applicant meets the following requirements: <ul> Professional or technical degree or equivalent in occupational therapy. Certified or licensed by and in good standing with an AOTA recognized credentialing or regulatory body. Minimum of 2,000 hours of experience as an occupational therapist or occupational therapy assistant. 600 hours of experience delivering occupational therapy services in the certification area to clients (individuals, groups, or populations) in the last 3 calendar years. Service delivery may be paid or voluntary. Verification of employment. AOTA Fact Sheets: Low Vision; OT Services for Individuals with Visual Impairments

Effective Date 10/1/2008

Orthotic Fitter

225000000X Orthotic Fitter

An individual trained in the management of fitting prefabricated orthoses.

Source: National Uniform Claim Committee [1/1/2011: title modified, definition modfied] Additional Resources: American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc., www.abcop.org and Board of Certification/Accreditation, International, www.bocusa.org.

Effective Date 4/1/2002 Last Modified Date 1/1/2011

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Orthotist

222Z00000X Orthotist

A health care professional who is specifically educated and trained to manage comprehensive orthotic patient care, including musculoskeletal and neuromuscular anomalies resulting from injuries or disease processes involving the lower extremity, upper extremity or spinal segment/s and positional deformation of the cranium. Orthotists assess specific patient needs, formulate an appropriate treatment plan, implement the treatment plan and provide follow-up care.

Source: American Board for Certification in Orthotics, Prosthetics, and Pedorthics, Inc. [7/1/2010: modified, 7/1/2013: modified] Additional Resources: American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc., www.abcop.org and Board of Certification/Accreditation, International, www.bocusa.org.

Effective Date 4/1/2002 Last Modified Date 7/1/2013

Pedorthist

224L00000X Pedorthist

An individual who is trained in the management and treatment of conditions of the foot, ankle, and lower extremities requiring fitting, fabricating, and adjusting of pedorthic devices.

Source: National Uniform Claim Committee [7/1/2010: new] Additional Resources: American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc., www.abcop.org and Board of Certification/Accreditation, International, www.bocusa.org.

Effective Date 10/1/2010

Physical Therapist

225100000X Physical Therapist

Physical therapists (PTs) are licensed health care professionals who diagnose and treat individuals of all ages, from newborns to the very oldest, who have medical problems or other health-related conditions that limit their abilities to move and perform functional activities in their daily lives. PTs examine each individual and develop a plan using treatment techniques to promote the ability to move, reduce pain, restore function, and prevent disability. In addition, PTs work with individuals to prevent the loss of mobility before it occurs by developing fitness- and wellness-oriented programs for healthier and more active lifestyles. PTs: 1.Diagnose and manage movement dysfunction and enhance physical and functional abilities. 2.Restore, maintain, and promote not only optimal physical function but optimal wellness and fitness and optimal quality of life as it relates to movement and health. 3.Prevent the onset, symptoms, and progression of impairments, functional limitations, and disabilities that may result from diseases, disorders, conditions, or injuries. 4.Treat conditions of the musculoskeletal, neuromuscular, cardiovascular, pulmonary, and/or integumentary systems. 5.Address the negative effects attributable to unique personal and environmental factors as they relate to human performance. 6.PTs provide care for people in a variety of settings, including hospitals, private practices, outpatient clinics, home health agencies, schools, sports and fitness facilities, work settings, and nursing homes. State licensure is required in each state in which a PT practices.

Source: American Physical Therapy Association [1/1/2020: definition modified] Additional resources: https://www.apta.org/PTCareers/RoleofaPT/

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Physical Therapist

Specialization: Cardiopulmonary

2251C2600X Cardiopulmonary Physical Therapist

A licensed physical therapist, including but not limited to an individual who is a Board Certified Specialist in Cardiovascular & Pulmonary Physical Therapy, who has demonstrated specialized knowledge and skill in cardiovascular and pulmonary anatomy and physiology medicine, rehabilitation, critical care, and emergency and trauma.

Source: American Physical Therapy Association [1/1/2020: definition added] Additional resources: http://www.abpts.org/uploadedFiles/ABPTSorg/Specialist_Certification/DSP/DSP-Cardio.pdf

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Specialization: Electrophysiology, Clinical

2251E1300X Clinical Electrophysiology Physical Therapist

A licensed physical therapist, including but not limited to an individual who is a Board Certified Specialist in Clinical Electrophysiologic Physical Therapy, who has demonstrated specialized knowledge and skill in electrophysiologic examinations and evaluations and encompasses both the professional and technical components of the observation, recording, analysis, and interpretation of bioelectric muscle and nerve potentials, detected by means of surface or needle electrodes, for the purpose of evaluating the integrity of the neuromuscular system. Electrophysiologic evaluations include, but are not limited to, electrodiagnostic testing, which includes clinical needle electromyography, motor and sensory nerve conduction studies, and other evoked potential procedures.

Source: American Physical Therapy Association [1/1/2020: definition added] Additional Resources: https://www.apta.org/apta-and-you/leadership-and-governance/policies/electrophysiologic-examination-evaluation ; http://www.abpts.org/Certification/ClinicalElectrophysiology/

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Specialization: Ergonomics

2251E1200X Ergonomics Physical Therapist

A licensed physical therapist who has demonstrated specialized knowledge and skills pertaining to the workplace, occupational demands, prevention of work-related injury, management of the worker with job-related symptoms or participation restrictions, and provides individual, group or population level evaluation, intervention and consulting to enhance worker performance.

Source: American Physical Therapy Association [1/1/2020: definition added] Additional Resources: www.apta.org

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Physical Therapist

Specialization: Geriatrics

2251G0304X Geriatric Physical Therapist

A licensed physical therapist, including but not limited to an individual who is a Board Certified Specialist in Geriatric Physical Therapy, who has demonstrated specialized knowledge and skill in the comprehensive biopsychosocial assessment and evidence-based management of movement in aging adults. This includes, but is not limited to, specialized knowledge in and consideration of normal age-related changes and pathological manifestations across all systems; cognition and mental health; polypharmacy; fall risk mitigation; bone health; healthy and active aging, and socioeconomic and health policy issues affecting aging adults. The geriatric physical therapist is an integral part of the interdisciplinary geriatric team and serves as an advocate for the highest level of well-being for the older adult.

Source: American Physical Therapy Association [1/1/2020: definition added] Additional resources: www.apta.org

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Specialization: Hand

2251H1200X Hand Physical Therapist

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Human Factors

2251H1300X Human Factors Physical Therapist

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Neurology

2251N0400X Neurology Physical Therapist

A licensed physical therapist, including but not limited to an individual who is a Board Certified Specialist in Neurologic Physical Therapy, who has demonstrated specialized knowledge and skill in neuroanatomy and neurophysiology, including knowledge of central, peripheral, and autonomic nervous systems in populations with and without neurologic conditions; motor control and movement sciences in populations with and without neurologic conditions; behavioral sciences, including psychology and neuropsychology, and psychiatry; and medical management and pharmacology.

Source: American Physical Therapy Association [1/1/2020: definition added] Additional resources: http://www.abpts.org/uploadedFiles/ABPTSorg/Specialist_Certification/DSP/DSP-Neurology.pdf

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Physical Therapist

Specialization: Orthopedic

2251X0800X Orthopedic Physical Therapist

A licensed physical therapist, including but not limited to an individual who is a Board Certified Specialist in Orthopaedic Physical Therapy, who has demonstrated specialized knowledge and skill in human anatomy and physiology, movement science; pathology/pathophysiology, pain science, medical and surgical considerations, orthopaedic physical therapy theory and practice, and critical inquiry for evidence-based practice.

Source: American Physical Therapy Association [1/1/2020: definition added] Additional resources: http://www.abpts.org/uploadedFiles/ABPTSorg/Specialist_Certification/DSP/DSP-Orthopaedics.pdf

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Specialization: Pediatrics

2251P0200X Pediatric Physical Therapist

A licensed physical therapist, including but not limited to an individual who is a Board Certified Specialist in Pediatric Physical Therapy, who has demonstrated specialized knowledge and skill in anatomy, histology, including embryonic development, genetics, biomechanics, neurological function, neuroscience, and pathology, behavioral sciences, and understanding of diseases or conditions that necessitate physical therapy care, that affect systems that in turn necessitate physical therapy care (comorbidities), and that influence the type of intervention that can be given.

Source: American Physical Therapy Association [1/1/2020: definition added] Additional resources: http://www.abpts.org/uploadedFiles/ABPTSorg/Specialist_Certification/DSP/DSP-Pediatrics.pdf

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Specialization: Sports

2251S0007X Sports Physical Therapist

A licensed physical therapist, including but not limited to an individual who is a Board Certified Specialist in Sports Physical Therapy, who has demonstrated specialized knowledge and skill in human anatomy and physiology, movement science, pathology and pathophysiology, medical and surgical intervention, and health and wellness, as well as rehabilitation/return to sports, management of acute injury/illness, medical and surgical consideration, injury prevention, and sports performance enhancement.

Source: American Physical Therapy Association [1/1/2020: definition added] Additional resources: http://www.abpts.org/uploadedFiles/ABPTSorg/Specialist_Certification/DSP/DSP-Sports.pdf

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Physical Therapy Assistant

225200000X Physical Therapy Assistant

(1)Physical therapist assistants are skilled health care providers who are graduates of a physical therapist assistant associate degree program accredited by an agency recognized by the Secretary of the U.S. Department of Education or Council on Postsecondary Accreditation, who assists the physical therapist in providing physical therapy. The supervising physical therapist is directly responsible for the actions of the physical therapist assistant. The PTA performs physical therapy procedures and related tasks that have been selected and delegated by the supervising physical therapist. Duties of the PTA include assisting the physical therapist in implementing treatment programs, training patients in exercised and activities of daily living, conducting treatments, and reporting to the physical therapist on the patient's responses. In addition to direct patient care, the PTA may also perform such functions as patient transport, and clinic or equipment preparation and maintenance. Currently more than half of all states require PTAs to be licensed, registered or certified. (2) An individual who works under the supervision of a physical therapist to assist him or her in providing physical therapy services. A physical therapy assistant may, for instance, help patients follow an appropriate exercise program that will increase their strength, endurance, coordination, and range of motion and train patients to perform activities of daily life.

Source: (1) American Physical Therapy Association, P.O. Box 37257, Washington, D.C. 20013. (2) Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL: 1994, p. 612

Effective Date 4/1/2002

Prosthetist

224P00000X Prosthetist

A health care professional who is specifically educated and trained to manage comprehensive prosthetic patient care for individuals who have sustained complete or partial limb loss or absence. Prosthetists assess specific patient needs, formulate an appropriate treatment plan, implement the treatment plan and provide follow-up care.

Source: American Board for Certification in Orthotics, Prosthetics, and Pedorthics, Inc. [7/1/2010: modified, 7/1/2013: modified] Additional Resources: American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc., www.abcop.org and Board of Certification/Accreditation, International, www.bocusa.org.

Effective Date 4/1/2002 Last Modified Date 7/1/2013

Pulmonary Function Technologist

225B00000X Pulmonary Function Technologist

An individual who is trained and qualified to perform pulmonary diagnostic tests. In the course of conducting these tests, the Pulmonary Function Technologist is able to setup, calibrate, maintain, and ensure the quality assurance of the pulmonary function testing equipment. In the laboratory, clinical or patient care setting the technologist instructs patients, elicits cooperation, performs procedures, monitors patient response, and evaluates patient performance. Tests results are calculated, compared with predicted normal ranges, and evaluated for reliability. The technologist collects clinical history data and evaluates the clinical implications of the test results.

#Type!

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Recreation Therapist

225800000X Recreation Therapist

A recreation therapist uses recreational activities for intervention in some physical, social or emotional behavior to bring about a desired change in that behavior and promote the growth and development of the patient.

Source: Joel A. DeLisa and Bruce M. Gans, Rehabilitation Medicine: Principles and Practice Second Edition, J.B. Lippincott Company, Philadelphia: 1993, p. 7

Effective Date 4/1/2002

Recreational Therapist Assistant

226000000X Recreational Therapist Assistant

Recreational Therapist Assistants work in support of or assistant to Recreational Therapists treating patients with disabilities, injuries, and illnesses. Recreational Therapist Assistants work in a variety of settings providing treatments using recreational activities, including games, sports, and crafts.

Source: National Uniform Claim Committee, 2015 [1/1/2016: new]

Effective Date 4/1/2016

Rehabilitation Counselor

225C00000X Rehabilitation Counselor

An individual trained and educated in a systematic process of assisting persons with physical, mental, developmental, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals assessment and appraisal, diagnosis and treatment planning, career (vocational) counseling, individual and group counseling interventions for adjustments to the medical and psychosocial impact of disability, case management, program evaluation and research, job analysis and placement counseling, and consultation on rehabilitation resources and technology. Certification generally requires a Master's degree with specialized courses in rehabilitation processes and technology.

Sources: Commission on Rehabilitation Counselor Certification and Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Specialization: Assistive Technology Practitioner

225CA2400X Assistive Technology Practitioner Rehabilitation Counselor

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Assistive Technology Supplier

225CA2500X Assistive Technology Supplier Rehabilitation Counselor

Definition to come...

#Type!

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Rehabilitation Counselor

Specialization: Orientation and Mobility Training Provider

225CX0006X Orientation and Mobility Training Rehabilitation Counselor

Orientation and Mobility (O&M) specialists teach children and adults who have visual impairments the specific orientation skills used to find one's way in the environment and the mobility skills needed to travel safely and efficiently at home, school, work, and in the community. Instruction is usually provided one-on-one and can include skills such as how to use a long cane, the operation of low vision devices and electronic travel aids when appropriate, how to orient oneself to new environments, navigate public transportation systems, how to cross streets safely, and traveling by using hearing, remaining vision, and other senses. In addition, O&M Specialists help children to develop fundamental skills such as fine and gross motor skills, concept development and problem solving skills. Adult clients can also benefit from an O&M specialist evaluating their current use of travel-related skills, discussing their future goals, and helping them select a program of instruction that will allow them to reach their greatest travel potential.

Source: San Francisco State University Orientation and Mobility Program web site http://online.sfsu.edu/~mobility/ [7/1/2006: new]

Effective Date 10/1/2006

Rehabilitation Practitioner

225400000X Rehabilitation Practitioner

A health care practitioner who trains or retrains individuals disabled by disease or injury to help them attain their maximum functional capacity.

#Type!

Effective Date 4/1/2002

Respiratory Therapist, Certified

227800000X Certified Respiratory Therapist

A Certified Respiratory Therapist (CRT) is a an entry level therapist who has passed a standardized written examination administered by the National Board for Respiratory Care (NBRC). CRTs provide diagnostic testing, therapeutics, monitoring, rehabilitation, and education to patients with disorders of the cardiopulmonary system. They provide these respiratory care services in all health care facilities and in the home. A CRT is a graduate of an associate degree program approved by the Commission on Accreditation of Allied Health Educational Programs (CAAHEP) and where applicable, is licensed by the state and is practicing within the scope of the license.

#Type!

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Respiratory Therapist, Certified

Specialization: Critical Care

2278C0205X Critical Care Certified Respiratory Therapist

Respiratory emergencies are commonplace in the treatment of critical care patients. Included in the assessment measurements conducted by the respiratory therapist in the critical care settings are arterial blood gas puncture and analysis, intrarterial monitoring, bedside measurements of lung mechanics, hemodynamic monitoring, and inspired and expired gas measurements. This is coupled with the initiation and management of mechanical ventilation patients.

#Type!

Effective Date 4/1/2002

Specialization: Educational

2278E1000X Educational Certified Respiratory Therapist

The focus of patient and family education activities is to promote knowledge of disease process, medical therapy, and self help. Respiratory therapists are uniquely qualified to provide this service in regard to cardiopulmonary diseases and injury.

#Type!

Effective Date 4/1/2002

Specialization: Emergency Care

2278E0002X Emergency Care Certified Respiratory Therapist

The immediate availability of diagnostic and therapeutic cardiopulmonary services in the assessment and management of trauma victims, patients requiring airway management and others requiring emergency care.

#Type!

Effective Date 4/1/2002

Specialization: General Care

2278G1100X General Care Certified Respiratory Therapist

This level of care includes diagnostics testing, therapeutics, monitoring, rehabilitation of patients with disorders of the cardiopulmonary system, as well as, education of the patient and family in regard to those disorders.

#Type!

Effective Date 4/1/2002

Specialization: Geriatric Care

2278G0305X Geriatric Care Certified Respiratory Therapist

Care of older patients who have age and/or disease related decremental pulmonary changes. Diagnosis and treatment is very important for this group since chronic lung disease is the major cause of morbidity and mortality among them. Furthermore, as this segment of the population increases, life expectancy is being extended.

#Type!

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Respiratory Therapist, Certified

Specialization: Home Health

2278H0200X Home Health Certified Respiratory Therapist

Home care fosters individual responsibility for self-management of chronic respiratory conditions. It includes individualized assessment based plans of care service developed to promote safe, proper, and sustained use of prescribed respiratory therapy medications, equipment, and techniques in the home.

#Type!

Effective Date 4/1/2002

Specialization: Neonatal/Pediatrics

2278P3900X Neonatal/Pediatric Certified Respiratory Therapist

The care and treatment of premature infants, newborns and children. This includes management of mechanical ventilation, assessment, diagnostics and generalized respiratory treatments.

#Type!

Effective Date 4/1/2002

Specialization: Palliative/Hospice

2278P3800X Palliative/Hospice Certified Respiratory Therapist

A coordinated plan of care to help dying patients and their families handle the burden of terminal care. Effective secretion management and relief of dyspnea are paramount in caring for patients with end-stage pulmonary disease.

#Type!

Effective Date 4/1/2002

Specialization: Patient Transport

2278P4000X Patient Transport Certified Respiratory Therapist

Transport respiratory therapist provide patient assessment, initiation of treatment modalities and continued monitoring of patient status of the critically ill and injured patients with special attention to advanced airway and ventilator management. The transport respiratory therapist knowledge and experience with complex neonatal, pediatric and adult patient care issues provides them with an expertise to assist with any patient care issue in a variety of transport modes.

#Type!

Effective Date 4/1/2002

Specialization: Pulmonary Diagnostics

2278P1004X Pulmonary Diagnostics Certified Respiratory Therapist

Included in the area of pulmonary diagnostics are the following; collection and analysis of physiological specimens, interpretation of physiological data, administration of tests of the cardiopulmonary system, and the conduct of both neurophysiological and sleep disorders studies.

#Type!

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Respiratory Therapist, Certified

Specialization: Pulmonary Function Technologist

2278P1006X Pulmonary Function Technologist Certified Respiratory Therapist

An individual who is trained and qualified to perform pulmonary diagnostic tests. In the course of conducting these tests, the Pulmonary Function Technologist is able to setup, calibrate, maintain, and ensure the quality assurance of the pulmonary function testing equipment. In the laboratory, clinical or patient care setting the technologist instructs patients, elicits cooperation, performs procedures, monitors patient response, and evaluates patient performance. Tests results are calculated, compared with predicted normal ranges, and evaluated for reliability. The technologist collects clinical history data and evaluates the clinical implications of the test results.

#Type!

Effective Date 4/1/2002

Specialization: Pulmonary Rehabilitation

2278P1005X Pulmonary Rehabilitation Certified Respiratory Therapist

The respiratory therapist can assist the chronic pulmonary patient in returning to an optimal role in society by providing an effective program. It includes bronchopulmonary drainage, exercise therapy, and patient education.

#Type!

Effective Date 4/1/2002

Specialization: SNF/Subacute Care

2278S1500X SNF/Subacute Care Certified Respiratory Therapist

Care of residents in a long-term care environment. Respiratory modalities delivered include those similar in the general care and critical care areas but provided to less critical patients.

#Type!

Effective Date 4/1/2002

Respiratory Therapist, Registered

227900000X Registered Respiratory Therapist

A Registered Respiratory Therapist (RRT) is an advanced therapist who has passed standardized written and clinical simulation examinations administered by the National Board for Respiratory Care (NBRC). In addition, to the certified therapist (CRT) entry level skills, RRTs have advanced education and training in patient assessment, in the development and modification of patient care plans, and in assuring the appropriate utilization of respiratory care resources. An RRT is a graduate of an associate or baccalaureate degree producing educational programs approved by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and where applicable, is licensed by the state and is practicing within the scope of that license.

#Type!

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Respiratory Therapist, Registered

Specialization: Critical Care

2279C0205X Critical Care Registered Respiratory Therapist

Respiratory emergencies are commonplace in the treatment of critical care patients. Included in the assessment measurements conducted by the respiratory therapist in the critical care settings are arterial blood gas puncture and analysis, intrarterial monitoring, bedside measurements of lung mechanics, hemodynamic monitoring, and inspired and expired gas measurements. This is coupled with the initiation and management of mechanical ventilation patients.

#Type!

Effective Date 4/1/2002

Specialization: Educational

2279E1000X Educational Registered Respiratory Therapist

The focus of patient and family education activities is to promote knowledge of disease process, medical therapy, and self help. Respiratory therapists are uniquely qualified to provide this service in regard to cardiopulmonary diseases and injury.

#Type!

Effective Date 4/1/2002

Specialization: Emergency Care

2279E0002X Emergency Care Registered Respiratory Therapist

The immediate availability of diagnostic and therapeutic cardiopulmonary services in the assessment and management of trauma victims, patients requiring airway management and others requiring emergency care.

#Type!

Effective Date 4/1/2002

Specialization: General Care

2279G1100X General Care Registered Respiratory Therapist

This level of care includes diagnostics testing, therapeutics, monitoring, rehabilitation of patients with disorders of the cardiopulmonary system, as well as, education of the patient and family in regard to those disorders.

#Type!

Effective Date 4/1/2002

Specialization: Geriatric Care

2279G0305X Geriatric Care Registered Respiratory Therapist

Care of older patients who have age and/or disease related decremental pulmonary changes. Diagnosis and treatment is very important for this group since chronic lung disease is the major cause of morbidity and mortality among them. Furthermore, as this segment of the population increases, life expectancy is being extended.

#Type!

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Respiratory Therapist, Registered

Specialization: Home Health

2279H0200X Home Health Registered Respiratory Therapist

Home care fosters individual responsibility for self-management of chronic respiratory conditions. It includes individualized assessment based plans of care service developed to promote safe, proper, and sustained use of prescribed respiratory therapy medications, equipment, and techniques in the home.

#Type!

Effective Date 4/1/2002

Specialization: Neonatal/Pediatrics

2279P3900X Neonatal/Pediatric Registered Respiratory Therapist

The care and treatment of premature infants, newborns and children. This includes management of mechanical ventilation, assessment, diagnostics and generalized respiratory treatments.

#Type!

Effective Date 4/1/2002

Specialization: Palliative/Hospice

2279P3800X Palliative/Hospice Registered Respiratory Therapist

A coordinated plan of care to help dying patients and their families handle the burden of terminal care. Effective secretion management and relief of dyspnea are paramount in caring for patients with end-stage pulmonary disease.

#Type!

Effective Date 4/1/2002

Specialization: Patient Transport

2279P4000X Patient Transport Registered Respiratory Therapist

Transport respiratory therapist provide patient assessment, initiation of treatment modalities and continued monitoring of patient status of the critically ill and injured patients with special attention to advanced airway and ventilator management. The transport respiratory therapist knowledge and experience with complex neonatal, pediatric and adult patient care issues provides them with an expertise to assist with any patient care issue in a variety of transport modes.

#Type!

Effective Date 4/1/2002

Specialization: Pulmonary Diagnostics

2279P1004X Pulmonary Diagnostics Registered Respiratory Therapist

Included in the area of pulmonary diagnostics are the following; collection and analysis of physiological specimens, interpretation of physiological data, administration of tests of the cardiopulmonary system, and the conduct of both neurophysiological and sleep disorders studies.

#Type!

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Respiratory Therapist, Registered

Specialization: Pulmonary Function Technologist

2279P1006X Pulmonary Function Technologist Registered Respiratory Therapist

An individual who is trained and qualified to perform pulmonary diagnostic tests. In the course of conducting these tests, the Pulmonary Function Technologist is able to setup, calibrate, maintain, and ensure the quality assurance of the pulmonary function testing equipment. In the laboratory, clinical or patient care setting the technologist instructs patients, elicits cooperation, performs procedures, monitors patient response, and evaluates patient performance. Tests results are calculated, compared with predicted normal ranges, and evaluated for reliability. The technologist collects clinical history data and evaluates the clinical implications of the test results.

#Type!

Effective Date 4/1/2002

Specialization: Pulmonary Rehabilitation

2279P1005X Pulmonary Rehabilitation Registered Respiratory Therapist

The respiratory therapist can assist the chronic pulmonary patient in returning to an optimal role in society by providing an effective program. It includes bronchopulmonary drainage, exercise therapy, and patient education.

#Type!

Effective Date 4/1/2002

Specialization: SNF/Subacute Care

2279S1500X SNF/Subacute Care Registered Respiratory Therapist

Care of residents in a long-term care environment. Respiratory modalities delivered include those similar in the general care and critical care areas but provided to less critical patients.

#Type!

Effective Date 4/1/2002

Specialist/Technologist

225500000X Respiratory/Developmental/Rehabilitative Specialist/Technologist

General classification identifying individuals who are trained on a specific piece of equipment or technical procedure.

#Type!

Effective Date 4/1/2002

Respiratory, Developmental, Rehabilitative and Restorative Service Providers

Specialist/Technologist

Specialization: Athletic Trainer

2255A2300X **Athletic Trainer**

Athletic trainers are allied health care professionals who work in consultation with or under the direction of physicians, and specialize in the prevention, assessment, treatment and rehabilitation of injuries and illnesses. Currently, the entry-level employment requirements are a bachelor's degree with a major in athletic training from an accredited university or college. A majority of athletic trainers hold advanced degrees. National board certification is generally required as a condition of state licensure and employment. Most states regulate athletic trainers, and they practice within the scope of that license or regulation. Clinical practice includes emergency care, rehabilitation, reconditioning, therapeutic exercise, wellness programs, exercise physiology, kinesiology, biomechanics, nutrition, psychology and health care administration.

Source: National Athletic Trainers' Association (www.NATA.org) [1/1/2006: modified definition, modified source]

Effective Date 4/1/2002 Last Modified Date 1/1/2006

Specialization: Rehabilitation, Blind

2255R0406X **Blind Rehabilitation Specialist/Technologist**

Definition to come...

#Type!

Effective Date 4/1/2002

Speech, Language and Hearing Service Providers

Audiologist

231H00000X **Audiologist**

(1) A specialist in evaluation, habilitation and rehabilitation of those whose communication disorders center in whole or in part in hearing function. Audiologists are autonomous professionals who identify, assess, and manage disorders of the auditory, balance and other neural systems. Audiologists provide audiological (aural) rehabilitation to children and adults across the entire age span. Audiologists select, fit and dispense amplification systems such as hearing aids and related devices. (2) An audiologist is a person qualified by a master's degree in audiology, licensed by the state, where applicable, and practicing within the scope of that license. Audiologists evaluate and treat patients with impaired hearing. They plan, direct and conduct rehabilitative programs with audiotry substitutional devises (hearing aids) and other therapy.

Source: (1) American Speech-Language-Hearing Association, (1996, Spring) Scope of practice in Audiology, p. 2

Effective Date 4/1/2002

Speech, Language and Hearing Service Providers

Audiologist

Specialization: Assistive Technology Practitioner

231HA2400X Assistive Technology Practitioner Audiologist

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Assistive Technology Supplier

231HA2500X Assistive Technology Supplier Audiologist

Definition to come...

#Type!

Effective Date 4/1/2002

Audiologist-Hearing Aid Fitter

237600000X Audiologist-Hearing Aid Fitter

An audiologist/hearing aid fitter is the professional who specializes in evaluating and treating people with hearing loss, conducts a wide variety of tests to determine the exact nature of an individual's hearing problem, presents a variety of treatment options to patients, dispenses and fits hearing aids, administers tests of balance to evaluate dizziness and provides hearing rehabilitation training. This classification should be used where individuals are licensed as "audiologist-hearing aid fitters" as opposed to states that license individuals as "audiologists".

Source: American Academy of Audiology, 1735 N. Lynn St, Suite 950, Arlington VA 22209, (800)AAA-2336)

Effective Date 4/1/2002

Hearing Instrument Specialist

237700000X Hearing Instrument Specialist

Individuals who test hearing for the selection, adaptation, fitting, adjusting, servicing, and sale of hearing aids. Hearing Instrument Specialist is a designation provided individuals who qualify by the National Hearing Aid Society

#Type!

Effective Date 4/1/2002

Specialist/Technologist

235500000X Speech/Language/Hearing Specialist/Technologist

General classification identifying individuals who are trained on a specific piece of equipment or technical procedure.

#Type!

Effective Date 4/1/2002

Speech, Language and Hearing Service Providers

Specialist/Technologist

Specialization: Audiology Assistant

2355A2700X **Audiology Assistant**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Speech-Language Assistant

2355S0801X **Speech-Language Assistant**

Definition to come...

#Type!

Effective Date 4/1/2002

Speech-Language Pathologist

235Z00000X **Speech-Language Pathologist**

The speech-language pathologist is the professional who engages in clinical services, prevention, advocacy, education, administration, and research in the areas of communication and swallowing across the life span from infancy through geriatrics. Speech-language pathologists address typical and atypical impairments and disorders related to communication and swallowing in the areas of speech sound production, resonance, voice, fluency, language (comprehension and expression), cognition, and feeding and swallowing.

"Scope of Practice in Speech-Language Pathology", American Speech-Language-Hearing Association, 2013.

Effective Date 4/1/2002 Last Modified Date 1/1/2014

Student, Health Care

Student in an Organized Health Care Education/Training Program

390200000X **Student in an Organized Health Care Education/Training Program**

An individual who is enrolled in an organized health care education/training program leading to a degree, certification, registration, and/or licensure to provide health care.

[1/1/2005: new]

Effective Date 4/1/2005

Technologists, Technicians & Other Technical Service Providers

Perfusionist

242T00000X Perfusionist

A perfusionist operates extracorporeal circulation and autotransfusion equipment during any medical situation where it is necessary to support or temporarily replace the patient's circulatory or respiratory function. The perfusionist is knowledgeable concerning the variety of equipment available to perform extracorporeal circulation functions and is responsible, in consultation with the physician, for selecting the appropriate equipment and techniques to be used.

Source: Health Professions Career and Education Directory, American Medical Association [1/1/2007: new]

Effective Date 4/1/2007

Radiologic Technologist

247100000X Radiologic Technologist

A medical imaging or radiation therapy professional who is appropriately educated and trained to perform medical imaging procedures using ionizing and nonionizing radiation.

Source: American Society of Radiologic Technologists, https://www.asrt.org/ [1/1/2024: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Specialization: Bone Densitometry

2471B0102X Bone Densitometry Radiologic Technologist

A radiologic technologist who specializes in bone densitometry and is appropriately educated and trained, consistent with nationally recognized standards, state statute, and facility policy, in performance of bone density imaging, exam techniques, equipment protocols, radiation safety, and patient care.

Source: American Society of Radiologic Technologists, https://www.asrt.org/ [1/1/2024: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Specialization: Cardiac-Interventional Technology

2471C1106X Cardiac-Interventional Technology Radiologic Technologist

A radiologic technologist who specializes in cardiac interventional and is appropriately educated and trained, consistent with nationally recognized standards, state statute, and facility policy, in cardiac interventional technology imaging, exam techniques, equipment protocols, radiation safety, and patient care.

Source: American Society of Radiologic Technologists, https://www.asrt.org/ [1/1/2024: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Technologists, Technicians & Other Technical Service Providers

Radiologic Technologist

Specialization: Cardiovascular-Interventional Technology

2471C1101X **Cardiovascular-Interventional Technology Radiologic Technologist**

A radiologic technologist who specializes in cardiovascular interventional technology.

Source: American Registry of Radiologic Technologists, https://www.arrt.org/. At this time, ARRT no longer offers new credentials in Cardiovascular Interventional Technology. [1/1/2024: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Specialization: Computed Tomography

2471C3401X **Computed Tomography Radiologic Technologist**

A radiologic technologist who specializes in computed tomography (CT) and is appropriately educated and trained, consistent with nationally recognized standards, state statute, and facility policy in performance of CT imaging, exam techniques, equipment protocols, radiation safety, and patient care.

Source: American Society of Radiologic Technologists, https://www.asrt.org/ [1/1/2024: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Specialization: Magnetic Resonance Imaging

2471M1202X **Magnetic Resonance Imaging Radiologic Technologist**

A radiologic technologist who specializes in magnetic resonance imaging (MRI) and is appropriately educated and trained, consistent with nationally recognized standards, state statute, and facility policy in performance of MRIs, exam techniques, equipment protocols, radiation safety, and patient care.

Source: American Society of Radiologic Technologists, https://www.asrt.org/ [1/1/2024 Definition modified]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Specialization: Mammography

2471M2300X **Mammography Radiologic Technologist**

A radiologic technologist who specializes in mammography and is appropriately educated and trained, consistent with nationally recognized standards, state statute, and facility policy in performance of mammogram imaging, exam techniques, equipment protocols, radiation safety, and patient care.

Source: American Society of Radiologic Technologists, https://www.asrt.org/ [1/1/2024: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Specialization: Nuclear Medicine Technology

2471N0900X **Nuclear Medicine Technology Radiologic Technologist**

A radiologic technologist who specializes in nuclear medicine technology and is appropriately educated and trained, consistent with nationally recognized standards, state statute, and facility policy in performance of nuclear medicine imaging, administration of radiopharmaceuticals to patients, exam techniques, equipment protocols, radiation safety, and patient care.

Source: American Society of Radiologic Technologists, https://www.asrt.org/ [1/1/2024: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Technologists, Technicians & Other Technical Service Providers

Radiologic Technologist

Specialization: Quality Management

2471Q0001X Quality Management Radiologic Technologist

A radiologic technologist who specializes in quality management.

Source: American Registry of Radiologic Technologists, https://www.arrt.org/. At this time, ARRT no longer offers new credentials in Quality Management. [1/1/2024: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Specialization: Radiation Therapy

2471R0002X Radiation Therapy Radiologic Technologist

A radiologic technologist who specializes in radiation therapy and is appropriately educated and trained, consistent with nationally recognized standards, state statute, and facility policy, in administration of radiation therapy, exam techniques, equipment protocols, radiation safety, and patient care.

Source: American Society of Radiologic Technologists, https://www.asrt.org/ [1/1/2024: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Specialization: Radiography

2471C3402X Radiography Radiologic Technologist

A radiologic technologist who specializes in radiography (also known as x-rays) and is appropriately educated and trained, consistent with nationally recognized standards, state statute, and facility policy in performance of radiographs, exam techniques, equipment protocols, radiation safety, and patient care.

Source: American Society of Radiologic Technologists, https://www.asrt.org/ [1/1/2024: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Specialization: Sonography

2471S1302X Sonography Radiologic Technologist

A radiologic technologist who specializes in sonography and is appropriately educated and trained, consistent with nationally recognized standards, state statute, and facility policy in performance of ultrasounds, exam techniques, equipment protocols, radiation safety, and patient care.

Source: American Society of Radiologic Technologists, https://www.asrt.org/ [1/1/2024 Definition modified]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Specialization: Vascular Sonography

2471V0105X Vascular Sonography Radiologic Technologist

A radiologic technologist who specializes in vascular sonography and is trained in the use of ultrasound equipment to image veins and arteries, which health care providers use to diagnose and treat various vascular conditions.

Source: American Registry of Radiologic Technologists, https://www.arrt.org/. At this time, ARRT no longer offers new credentials in Quality Management. [1/1/2024: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Technologists, Technicians & Other Technical Service Providers

Radiologic Technologist

Specialization: Vascular-Interventional Technology

2471V0106X Vascular-Interventional Technology Radiologic Technologist

A radiologic technologist who specializes in vascular interventional and is appropriately educated and trained, consistent with nationally recognized standards, state statute, and facility policy in performance of vascular interventional imaging, exam techniques, equipment protocols, radiation safety, and patient care.

Source: American Society of Radiologic Technologists, https://www.asrt.org/ [1/1/2024: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2024

Radiology Practitioner Assistant

243U00000X Radiology Practitioner Assistant

A Radiology Practitioner Assistant (RPA) is a health professional certified as a registered radiographer with the American Registry of Radiologic Technologists (ARRT) and, in addition, is credentialed to provide primary radiology health care with radiologist supervision. Radiology Practitioner Assistants are qualified by graduation from an educational program recognized by the Board of Directors of athe Certification Board for Radiology Practitioner Assistants (CBRPA) and certified by the CBRPA. Within the Radiologist/RPA relationship, Radiology Practitioner Assistants exercise autonomy in decision making in the role of a primary caregiver with regard to patient assessment, patient management and in providing a broad range of radiology diagnostic and interventional services. The clinical role of the Radiology Practitioner Assistant includes primary and specialty care in radiology practice settings in rural and urban areas.

Source: Certification Board of Radiology Practitioner Assistants [7/1/2008: new] Additional Resources: www.cbrpa.org

Effective Date 10/1/2008

Specialist/Technologist Cardiovascular

246X00000X Cardiovascular Specialist/Technologist

An allied health professional who performs diagnostic examinations at the request or direction of a physician in one or more of the following three areas: invasive cardiology, noninvasive cardiology, and noninvasive peripheral vascular study. Cardiovascular technologists are one type of allied health professional for which the Committee on Allied Health Education and Accreditation has accredited education programs

Source: (1) Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 159.

Effective Date 4/1/2002

Specialization: Cardiovascular Invasive Specialist

246XC2901X Cardiovascular Invasive Specialist/Technologist

Definition to come...

#Type!

Effective Date 4/1/2002

Technologists, Technicians & Other Technical Service Providers

Specialist/Technologist Cardiovascular

Specialization: Sonography

246XS1301X **Sonography Specialist/Technologist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Vascular Specialist

246XC2903X **Vascular Specialist/Technologist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialist/Technologist, Health Information

246Y00000X **Health Information Specialist/Technologist**

An individual with a high school diploma, on-the-job experience and coding education from seminars or college classes who passes a national certification examination in either inpatient and outpatient facility services coding, or physician services coding.

Source: American Health Information Management Association, Chicago, IL, 1996.

Effective Date 4/1/2002

Specialization: Coding Specialist, Hospital Based

246YC3301X **Hospital Based Coding Specialist**

None

[1/1/2023: marked inactive]
Deactivation Date: 3/31/2023

Effective Date 4/1/2002 Last Modified Date 1/1/2023 Deactivation Date 3/31/2023

Specialization: Coding Specialist, Physician Office Based

246YC3302X **Physician Office Based Coding Specialist**

None

[1/1/2023: marked inactive]
Deactivation Date: 3/31/2023

Effective Date 4/1/2002 Last Modified Date 1/1/2023 Deactivation Date 3/31/2023

Specialization: Registered Record Administrator

246YR1600X **Registered Record Administrator**

None

[1/1/2023: marked inactive]
Deactivation Date: 3/31/2023

Effective Date 4/1/2002 Last Modified Date 1/1/2023 Deactivation Date 3/31/2023

Technologists, Technicians & Other Technical Service Providers

Specialist/Technologist, Other

246Z00000X **Other Specialist/Technologist**

General classification identifying individuals trained on specific equipment and technical procedures in one of a collection of miscellaneous healthcare disciplines.

#Type!

Effective Date 4/1/2002

Specialization: Art, Medical

246ZA2600X **Medical Art Specialist/Technologist**

None

[1/1/2023: marked inactive]
Deactivation Date: 3/31/2023

Effective Date 4/1/2002 Last Modified Date 1/1/2023 Deactivation Date 3/31/2023

Specialization: Biochemist

246ZB0500X **Biochemist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Biomedical Engineering

246ZB0301X **Biomedical Engineer**

None

[1/1/2023: marked inactive]
Deactivation Date: 3/31/2023

Effective Date 4/1/2002 Last Modified Date 1/1/2023 Deactivation Date 3/31/2023

Specialization: Biomedical Photographer

246ZB0302X **Biomedical Photographer**

None

[1/1/2023: marked inactive]
Deactivation Date: 3/31/2023

Effective Date 4/1/2002 Last Modified Date 1/1/2023 Deactivation Date 3/31/2023

Specialization: Biostatistician

246ZB0600X **Biostatiscian**

None

[1/1/2023: marked inactive]
Deactivation Date: 3/31/2023

Effective Date 4/1/2002 Last Modified Date 1/1/2023 Deactivation Date 3/31/2023

Technologists, Technicians & Other Technical Service Providers

Specialist/Technologist, Other

Specialization: EEG
246ZE0500X **EEG Specialist/Technologist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Electroneurodiagnostic
246ZE0600X **Electroneurodiagnostic Specialist/Technologist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Geneticist, Medical (PhD)
246ZG1000X **Medical Geneticist (PhD) Specialist/Technologist**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Graphics Methods
246ZG0701X **Graphics Methods Specialist/Technologist**

None

[1/1/2023: marked inactive]
Deactivation Date: 3/31/2023

Effective Date 4/1/2002 Last Modified Date 1/1/2023 Deactivation Date 3/31/2023

Specialization: Illustration, Medical
246ZI1000X **Medical Illustrator**

None

[1/1/2023: marked inactive]
Deactivation Date: 3/31/2023

Effective Date 4/1/2002 Last Modified Date 1/1/2023 Deactivation Date 3/31/2023

Specialization: Nephrology
246ZN0300X **Nephrology Specialist/Technologist**

Definition to come...

#Type!

Effective Date 4/1/2002

Technologists, Technicians & Other Technical Service Providers

Specialist/Technologist, Other

Specialization: Orthopedic Assistant

246ZX2200X Orthopedic Assistant

An Orthopaedic Assistant is a person who has been trained to work as a physician extender in both clinical and surgical environments. An Orthopaedic Assistant assists with aspects of patient care as determined by the supervising surgeon including, but not limited to, obtaining patient history, assisting with examinations, injections, recording of office notes, and application/adjustment/removal of splints, casts, and other immobilization devices. Acting as a surgical first assistant for orthopaedic surgery cases includes providing aid in exposure, hemostasis, positioning of the patient, suturing and closure of body planes and skin, application of wound dressings or immobilization devices, and other technical functions that will help the surgeon carry out a safe operation with optimal results for the patient. An Orthopaedic Assistant may be licensed, registered, or certified depending on the state in which the individual practices.

Source: American Society of Orthopaedic Assistants (ASOA), 2014 [7/1/2014: new] Additional Resources: National Board for Certification of Orthopaedic Assistants

Effective Date 10/1/2014

Specialization: Surgical Assistant

246ZC0007X Surgical Assistant

A surgical assistant is a skilled practitioner who has undergone formalized education and training as a surgical assistant. The surgical assistant performs surgical functions that include, but are not limited to: retracting, manipulating, suturing, clamping, cauterizing, litigating, and tying tissue; suctioning, irrigating and sponging; positioning the patient; closure of body planes and skin; and participating in hemostasis and volume replacement. Surgical assistants are certified and registered or licensed by the state, or, in states without licensure, certified as surgical assistants by completing appropriate education and training.

Source: Association of Surgical Assistants, 2014. [7/1/2007: new, 7/1/2014: title modified, definition modified] http://www.surgicalassistant.org/index.php/surgical-assisting Additional Resources: National Surgical Assistant Association, www.nsaa.net.

Effective Date 10/1/2007 Last Modified Date 7/1/2014

Specialization: Surgical Technologist

246ZS0410X Surgical Technologist

Surgical technologists are allied health professionals, who are an integral part of the team of medical practitioners providing surgical care to patients. Surgical technologists work under the supervision of a surgeon to facilitate the safe and effective conduct of invasive surgical procedures, ensuring that the operating room environment is safe, that equipment functions properly, and that the operative procedure is conducted under conditions that maximize patient safety. Surgical technologists possess expertise in the theory and application of sterile and aseptic technique and combine the knowledge of human anatomy, surgical procedures, and implementation tools and technologies to facilitate a physician's performance of invasive therapeutic and diagnostic procedures.

Source: Association of Surgical Technologists, "Job Description: Surgical Technologist," 2014. [7/1/2014: code modified, title modified, definition added]

Effective Date 4/1/2002 Last Modified Date 7/1/2014

Technologists, Technicians & Other Technical Service Providers

Specialist/Technologist, Pathology

246Q00000X Pathology Specialist/Technologist

(1) An individual educated and trained in clinical chemistry, microbiology or other biological sciences; and in gathering data on the blood, tissues, and fluids in the human body. Tests and procedures performed or supervised center on major areas of hematology, microbiology, immunohematology, immunology, clinical chemistry and urinalysis. Education and certification requires the equivalent of an associate degree and alternative combinations of accredited training and experience. (2) A specially trained individual who works under the direction of a pathologist, other physician, or scientist, and performs specialized chemical, microscopic, and bacteriological tests of human blood, tissue, and fluids. Also known as medical technologists, they perform and supervise tests and procedures in clinical chemistry, immunology, serology, bacteriology, hematology, parasitology, mycology, urinalysis, and blood banking. The work requires the correlation of test results with other data, interpretation of test findings, and exercise of independent judgment. The minimum educational requirement (for one of several certification programs in medical technology) is a baccalaureate degree with appropriate science course requirements, plus a twelve-month, structured, AMA approved medical technology program and an examination; or a baccalaureate degree with appropriate science course requirements and experience.

#Type!

Effective Date 4/1/2002

Specialization: Blood Banking

246QB0000X Blood Banking Specialist/Technologist

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Chemistry

246QC1000X Chemistry Pathology Specialist/Technologist

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Cytotechnology

246QC2700X Cytotechnology Specialist/Technologist

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Hemapheresis Practitioner

246QH0401X Hemapheresis Practitioner

Definition to come...

#Type!

Effective Date 4/1/2002

Technologists, Technicians & Other Technical Service Providers

Specialist/Technologist, Pathology

Specialization: Hematology
246QH0000X **Hematology Specialist/Technologist**
Definition to come...
#Type!
Effective Date 4/1/2002

Specialization: Histology
246QH0600X **Histology Specialist/Technologist**
Definition to come...
#Type!
Effective Date 4/1/2002

Specialization: Immunology
246QI0000X **Immunology Pathology Specialist/Technologist**
Definition to come...
#Type!
Effective Date 4/1/2002

Specialization: Laboratory Management
246QL0900X **Laboratory Management Specialist/Technologist**
Definition to come...
#Type!
Effective Date 4/1/2002

Specialization: Laboratory Management, Diplomate
246QL0901X **Diplomate Laboratory Management Specialist/Technologist**
Definition to come...
#Type!
Effective Date 4/1/2002

Specialization: Medical Technologist
246QM0706X **Medical Technologist**
Definition to come...
#Type!
Effective Date 4/1/2002

Technologists, Technicians & Other Technical Service Providers

Specialist/Technologist, Pathology

Specialization: Microbiology

246QM0900X Microbiology Specialist/Technologist

Definition to come...

#Type!

Effective Date 4/1/2002

Technician, Cardiology

246W00000X Cardiology Technician

An individual who has knowledge of specific techniques, instruments, and equipment required in performing specific cardiovascular/peripheral vascular diagnostic procedures.

#Type!

Effective Date 4/1/2002

Technician, Health Information

247000000X Health Information Technician

Preferred term for an Accredited Record Technician who is an individual with an associate's degree from an accredited college or independent study program who is skilled in analyzing health information and in examination of medical records for accuracy, reporting of patient data for reimbursement, and creation of disease registries for researchers.

Source: American Health Information Management Association, Chicago, IL, 1996.

Effective Date 4/1/2002

Specialization: Assistant Record Technician

2470A2800X Assistant Health Information Record Technician

None

[1/1/2023: marked inactive]
Deactivation Date: 3/31/2023

Effective Date 4/1/2002 Last Modified Date 1/1/2023 Deactivation Date 3/31/2023

Technician, Other

247200000X Other Technician

A collective term for persons with specialized training in various narrow fields of expertise whose occupations require training and skills in specific technical processes and procedures; and where further classification is deemed unnecessary by the user.

Sources: Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988; Dorland's Illustrated Medical Dictionary, 26th Edition. Philadelphia: W.B. Saunders Company, 1981; and Webster's II New Riverside University Dictionary. Boston: Riverside Publishing Company, 1984.

Effective Date 4/1/2002

Technologists, Technicians & Other Technical Service Providers

Technician, Other

Specialization: Biomedical Engineering

2472B0301X **Biomedical Engineering Technician**

None

[1/1/2023: marked inactive]
Deactivation Date: 3/31/2023

Effective Date 4/1/2002 Last Modified Date 1/1/2023 Deactivation Date 3/31/2023

Specialization: Darkroom

2472D0500X **Darkroom Technician**

None

[1/1/2023: marked inactive]
Deactivation Date: 3/31/2023

Effective Date 4/1/2002 Last Modified Date 1/1/2023 Deactivation Date 3/31/2023

Specialization: EEG

2472E0500X **EEG Technician**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Renal Dialysis

2472R0900X **Renal Dialysis Technician**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Veterinary

2472V0600X **Veterinary Technician**

None

[1/1/2023: marked inactive]
Deactivation Date: 3/31/2023

Effective Date 4/1/2002 Last Modified Date 1/1/2023 Deactivation Date 3/31/2023

Technician, Pathology

246R00000X **Pathology Technician**

An individual with knowledge of specific techniques and instruments who performs all of the routine tests in a medical laboratory and who has the ability to discriminate between similar factors that directly affect procedures and results.

#Type!

Effective Date 4/1/2002

Technologists, Technicians & Other Technical Service Providers

Technician, Pathology

Specialization: Clinical Laboratory Director, Non-physician

247ZC0005X **Clinical Laboratory Director (Non-physician)**

An individual who is state-licensed as a clinical laboratory director and meets the qualifications in the Clinical Laboratory Improvement Amendments of 1988 for non-physicians (non-MD/DO) as defined in the CFR 42 Part 493.1405.

Source: National Uniform Claim Committee [1/1/2007: new]

Effective Date 4/1/2007

Specialization: Histology

246RH0600X **Histology Technician**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Medical Laboratory

246RM2200X **Medical Laboratory Technician**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Phlebotomy

246RP1900X **Phlebotomy Technician**

Definition to come...

#Type!

Effective Date 4/1/2002

Agencies

Case Management

251B00000X **Case Management Agency**

An organization that is responsible for providing case management services. The agency provides services which assist an individual in gaining access to needed medical, social, educational, and/or other services. Case management services may be used to locate, coordinate, and monitor necessary appropriate services. It may be used to encourage the use of cost-effective medical care by referrals to appropriate providers and to discourage over utilization of costly services. Case management may also serve to provide necessary coordination of non-medical services such as vocational rehabilitation, education, employment, when the services provided enable the individual to function at the highest level.

Source: CMS State Medicaid Manual Section 4442.3 [7/1/2006: definition modified]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Agencies

Community/Behavioral Health

251S00000X Community/Behavioral Health Agency

A private or public agency usually under local government jurisdiction, responsible for assuring the delivery of community based mental health, intellectual disabilities, substance abuse and/or behavioral health services to individuals with those disabilities. Services may range from companion care, respite, transportation, community integration, crisis intervention and stabilization, supported employment, day support, prevocational services, residential support, therapeutic and supportive consultation, environmental modifications, intensive in-home therapy and day treatment, in addition to traditional mental health and behavioral treatment.

Source: National Medicaid EDI HIPAA NPI Sub Work Group [1/1/2007: modified definition, 1/1/2021: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2021

Day Training, Developmentally Disabled Services

251C00000X Developmentally Disabled Services Day Training Agency

These agencies are authorized to provide day habilitation services to developmentally disabled individuals who live in their homes. The function of day habilitation is to assist an individual to acquire and maintain those life skills that enable the individual to cope more effectively with the demands of independent living. Also to raise the level of the individual's physical, mental, social, and vocational functioning.

#Type!

Effective Date 4/1/2002

Early Intervention Provider Agency

252Y00000X Early Intervention Provider Agency

Early intervention services are an effective way to address the needs of infants and toddlers who have developmental delays or disabilities. The services are made available through a federal law known as the Individuals with Disabilities Education Act (IDEA). IDEA provides states and territories with specific requirements for providing early intervention services to infants and toddlers with special needs. In turn, each state and territory develops its own policies for carrying out IDEA and its requirements. Broadly speaking, early intervention services are special services for eligible infants and toddlers and their families. These services are designed to identify and meet children's needs in five developmental areas. These areas are: physical development, cognitive development, communication, social or emotional development, and adaptive development.

Source: National Dissemination Center for Children with Disabilities [7/1/2007: new] http://www.nichcy.org/pubs/parent/pa2txt.htm

Effective Date 10/1/2007

Agencies

Foster Care Agency

253J00000X Foster Care Agency

A Foster Care Agency is an agency that provides foster care as defined in the Code of Federal Regulations (CFR) as "24-hour substitute care for children outside their own homes." Foster care settings include, but are not limited to, nonrelative foster family homes, relative foster homes (whether payments are being made or not), group homes, emergency shelters, residential facilities, and pre-adoptive homes.

Source: Code Of Federal Regulations, Title 45, Volume 4, Part 1355, Section 57 [1/1/2008: new]

Effective Date 4/1/2008

Home Health

251E00000X Home Health Agency

A public agency or private organization, or a subdivision of such an agency or organization, that is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical therapy, speech-language pathology services, or occupational therapy, medical social services, and home health aide services. It has policies established by a professional group associated with the agency or organization (including at least one physician and one registered nurse) to govern the services and provides for supervision of such services by a physician or a registered nurse; maintains clinical records on all patients; is licensed in accordance with State or local law or is approved by the State or local licensing agency as meeting the licensing standards, where applicable; and meets other conditions found by the Secretary of Health and Human Services to be necessary for health and safety.

Source: CFR42 Chapter IV Part 484, http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr484_99.html [7/1/2007: definition added, source added]

Effective Date 4/1/2002 Last Modified Date 7/1/2007

Home Infusion

251F00000X Home Infusion Agency

Definition to come...

#Type!

Effective Date 4/1/2002

Hospice Care, Community Based

251G00000X Community Based Hospice Care Agency

Definition to come...

#Type!

Effective Date 4/1/2002

Agencies

In Home Supportive Care

253Z00000X In Home Supportive Care Agency

An In Home Supportive Care Agency provides services in the patient's home with the goal of enabling the patient to remain at home. The services provided may include personal care services such as hands-on assistance with activities of daily living (ADLs), e.g., eating, bathing, dressing, and bladder and bowel requirements; homemaker services and instrumental activities of daily living (IADLs), e.g., taking medications, shopping for groceries, laundry, housekeeping, and companionship; and/or supervision or cuing so that a person can perform tasks themselves.

Source: National Uniform Claim Committee, 2008 [7/1/2008: new]

Effective Date 10/1/2008

Local Education Agency (LEA)

251300000X Local Education Agency (LEA)

The term local education agency means a public board of education or other public authority legally constituted within a State to either provide administrative control or direction of, or perform a service function for public schools serving individuals ages 0 - 21 in a state, city, county, township, school district, or other political subdivision including a combination of school districts or counties recognized in a State as an administrative agency for its public schools. An LEA may provide, or employ professional who provide, services to children included in the Individuals with Disabilities Education Act (IDEA), such services may include, but are not limited to, such medical services as physical, occupational, and speech therapy.

Source: Portions of IDEA Regulations Part B (34 CFR Part 300.18, Assistance to States for the Education of Children with Disabilities) [1/1/2006: new]

Effective Date 4/1/2006

Nursing Care

251J00000X Nursing Care Agency

A Nursing Care Agency is an entity that provides skilled nursing care through the services of a Registered Nurse (RN) or a Licensed Practical Nurse (LPN), by employees, contracted individuals, or via a registry, in a variety of settings. The agency may engage in providing private duty nursing and/or staffing services.

Source: National Uniform Claim Committee, 2008 [7/1/2008: modified definition]

Effective Date 4/1/2002

Agencies

Program of All-Inclusive Care for the Elderly (PACE) Provider Organization

251T00000X PACE Provider Organization

A PACE provider organization is a not-for-profit private or public entity that is primarily engaged in providing PACE services(unique capitated managed care benefits for the frail elderly which include comprehensive medical and social services). The following characteristics also apply to a PACE organization. It must: have a governing board that includes community representation; be able to provide complete PACE services regardless of frequency or duration of services; have a physical site to provide adult day services; have a defined service area; have safeguards against conflict of interest; have demonstrated fiscal soundness and have a formal Participant Bill of Rights.

Source: Centers for Medicare and Medicaid, PACE Fact Sheet http://www.cms.hhs.gov/PACE/Downloads/PACEFactSheet.pdf [7/1/2006: new]

Effective Date 10/1/2006

Public Health or Welfare

251K00000X Public Health or Welfare Agency

Definition to come...

#Type!

Effective Date 4/1/2002

Supports Brokerage

251X00000X Supports Brokerage Agency

A provider of service/function that assists participating individuals to make informed decisions about what will work best for them is consistent with their needs and reflects their individual circumstances. Serving as the agent of the individual, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services and may include assistance with recruiting, screening, hiring, and training in-home support providers. A family or person-centered planning approach is used. Supports Brokerage offers practical skills training to enable families and individuals to remain independent. Examples of skills training include providing information on recruiting and hiring personal care workers, managing personal care workers and providing information on effective communication and problem solving. The service/function provides sufficient information to assure that individuals understand the responsibilities involved with self-direction and assist in the development of an effective back-up and emergency plan. Plans may elect to fulfill the requirement of this service/function using a self-directed case manager or creating a distinct service. The Supports Brokerage documents the need for assistive services, planning for and documenting the use of excess funds and locating and maintaining services.

Source: CMS Independence Plus Waiver template. [7/1/2006: new]

Effective Date 10/1/2006

Agencies

Voluntary or Charitable

251V00000X Voluntary or Charitable Agency

Definition to come...

#Type!

Effective Date 4/1/2002

Ambulatory Health Care Facilities

Clinic/Center

261Q00000X Clinic/Center

A facility or distinct part of one used for the diagnosis and treatment of outpatients. "Clinic/Center" is irregularly defined, sometimes being limited to organizations serving specialized treatment requirements or distinct patient/client groups (e.g., radiology, poor, and public health).

#Type!

Effective Date 4/1/2002

Specialization: Adolescent and Children Mental Health

261QM0855X Adolescent and Children Mental Health Clinic/Center

An entity, facility, or distinct part of a facility providing diagnostic, treatment, and prescriptive services related to mental and behavioral disorders in children and adolescents. Services may be provided to parents and family members of the patient in the form of conjoint, group, or individual therapy, and education and/or training.

[7/1/2003: new]

Effective Date 10/1/2003

Specialization: Adult Day Care

261QA0600X Adult Day Care Clinic/Center

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Adult Mental Health

261QM0850X Adult Mental Health Clinic/Center

An entity, facility, or distinct part of a facility providing diagnostic, treatment, and prescriptive services related to mental and behavioral disorders in adults.

[7/1/2003: new]

Effective Date 10/1/2003

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Ambulatory Family Planning Facility

261QA0005X Ambulatory Family Planning Facility

An abortion/family planning facility where services are provided at a fixed specific location. An Ambulatory Family Planning Facility does not provide overnight accommodations. The following procedures may be performed at an Ambulatory Family Planning Facility: abortions, laproscopy, hysterectomies, tubule ligation and other related procedures. Abortion is considered voluntary termination of pregnancy.

#Type!

Effective Date 4/1/2002

Specialization: Ambulatory Fertility Facility

261QA0006X Ambulatory Fertility Facility

A fertility facility, which may be licensed, registered, or certified in some states, that is not hospital-based, where services are provided at a fixed specific location. An Ambulatory Fertility Facility does not provide overnight accommodations. The following fertility procedures may be performed at an Ambulatory Fertility Facility: In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Embryo Transfer-Thaw (ET-T), Zygote Intrafallopian Transfer (ZIFT), Donor OOCYTE (DO)

#Type!

Effective Date 4/1/2002

Specialization: Ambulatory Surgical

261QA1903X Ambulatory Surgical Clinic/Center

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Amputee

261QA0900X Amputee Clinic/Center

An entity, facility, or distinct part of a facility providing counseling, fitting, custom design, prescriptive, and training services related to congenital or postoperative absence of all or part of a limb or limbs.

[7/1/2003: new]

Effective Date 10/1/2003

Specialization: Augmentative Communication

261QA3000X Augmentative Communication Clinic/Center

An entity, facility, or distinct part of a facility staffed by audiology and/or speech professionals with special training in the evaluation of a patient's potential for use of an augmentative communication device, determination of the most appropriate device, adjustment and maintenance of the device, and training the patient to use the device.

[7/1/2003: new]

Effective Date 10/1/2003

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Birthing

261QB0400X Birthing Clinic/Center

A freestanding birth center is a health facility other than a hospital where childbirth is planned to occur away from the pregnant woman's residence, and that provides prenatal, labor and delivery, and postpartum care, as well as other ambulatory services for women and newborns.

Source: Summarized from Social Security Act [42 U.S.C. 1396d(1)(3)(B)] [1/1/2013: added definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2013

Specialization: Community Health

261QC1500X Community Health Clinic/Center

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Corporate Health

261QC1800X Corporate Health Clinic/Center

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Critical Access Hospital

261QC0050X Critical Access Hospital Clinic/Center

An outpatient entity, facility, or distinct part of a facility within or affiliated with a Critical Access Hospital that provides access to primary care services for individuals in a small rural community and is Medicare certified.

[7/1/2003: new]

Effective Date 10/1/2003

Specialization: Dental

261QD0000X Dental Clinic/Center

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Developmental Disabilities

261QD1600X Developmental Disabilities Clinic/Center

An entity, facility, or distinct part of a facility providing comprehensive, multidiscipline diagnostic, treatment, therapy, training, and counseling services to children with congenital disorders that precipitate developmental delays and in many instances mental deficiencies (e.g., Cerebral Palsy, metabolic disorders, Sturge-Weber Syndrome, etc.).

[7/1/2003: new]

Effective Date 10/1/2003

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Emergency Care

261QE0002X **Emergency Care Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Endoscopy

261QE0800X **Endoscopy Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: End-Stage Renal Disease (ESRD) Treatment

261QE0700X **End-Stage Renal Disease (ESRD) Treatment Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Family Planning, Non-Surgical

261QF0050X **Non-Surgical Family Planning Clinic/Center**

An entity, facility, or distinct part of a facility, or mobile unit providing non-surgical, family planning/reproductive services including physical examination, laboratory services such as PAP or pregnancy tests; pregnancy, pregnancy prevention/contraceptive, and nutritional counseling, and contraceptives or prescriptions for contraceptives.

[7/1/2003: new]

Effective Date 10/1/2003

Specialization: Federally Qualified Health Center (FQHC)

261QF0400X **Federally Qualified Health Center (FQHC)**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Genetics

261QG0250X **Genetics Clinic/Center**

An entity, facility, or distinct part of a facility providing analysis of family history, genetic laboratory testing and analysis, diagnosis of genetic trait, prognosis and options. Laboratory studies may be outsourced.

[7/1/2003: new]

Effective Date 10/1/2003

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Health Service

261QH0100X **Health Service Clinic/Center**

Definition to come...

[7/1/2006: modified title]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Specialization: Hearing and Speech

261QH0700X **Hearing and Speech Clinic/Center**

An entity, facility, or distinct part of a facility providing diagnostic, treatment, prescriptive, and therapy services related to congenital and acquired conditions and diseases that affect hearing capacity and speech ability.

[7/1/2003: new]

Effective Date 10/1/2003

Specialization: Infusion Therapy

261QI0500X **Infusion Therapy Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Lithotripsy

261QL0400X **Lithotripsy Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Magnetic Resonance Imaging (MRI)

261QM1200X **Magnetic Resonance Imaging (MRI) Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Medical Specialty

261QM2500X **Medical Specialty Clinic/Center**

An entity, facility, or distinct part of a facility providing diagnostic, treatment, and prescriptive services related to a specific area of medical specialization. Frequently used for Title V related Children's Specialty services or to meet specific public health needs (e.g., infectious diseases or breast and cervical cancer).

[7/1/2003: new]

Effective Date 10/1/2003

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Medically Fragile Infants and Children Day Care

261QM3000X Medically Fragile Infants and Children Day Care

An entity, facility, or distinct part of a facility specially equipped and staffed to provide care for medically fragile children with varied and complex care needs (e.g., enteral or parental feeding, ostomy care, respiratory/ventilator care, medications and therapies, etc.).

[7/1/2003: new]

Effective Date 10/1/2003

Specialization: Mental Health (Including Community Mental Health Center)

261QM0801X Mental Health Clinic/Center (Including Community Mental Health Center)

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Methadone

261QM2800X Methadone Clinic

An entity, facility, or distinct part of a facility providing diagnostic, and replacement maintenance treatment services related to individuals with drug addiction.

[7/1/2003: new]

Effective Date 10/1/2003

Specialization: Migrant Health

261QM1000X Migrant Health Clinic/Center

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Military Ambulatory Procedure Visits Operational (Transportable)

261QM1103X Military Ambulatory Procedure Visits Operational (Transportable) Clinic/Center

"Non-fixed" facilities or distinct parts of a "non-fixed" facility, providing outpatient surgical procedures requiring medically supervised recovery. Does not include items issued directly to a patient from an outpatient pharmacy or patient transport. Includes initial "take home" pharmaceuticals.

[1/1/2005: new]

Effective Date 4/1/2005

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Military and U.S. Coast Guard Ambulatory Procedure

261QM1101X Military and U.S. Coast Guard Ambulatory Procedure Clinic/Center

That part of a "fixed" (non-temporary, non-deployed) DoD or Coast Guard entity furnishing surgical procedures requiring medically supervised recovery. Similar to a civilian ambulatory surgical center. May be in shared resources with a DoD or Coast Guard Clinic or a DoD Hospital. Does not include items issued directly to a patient from an outpatient pharmacy or patient transport. Includes initial "take home" pharmaceuticals.

Source: TRICARE Management Activity Uniform Business Office User's Guide [1/1/2005: title modified, definition added; 7/1/2006 title modified, definition modified]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Specialization: Military Outpatient Operational (Transportable) Component

261QM1102X Military Outpatient Operational (Transportable) Component Clinic/Center

"Non-fixed" facilities or distinct parts of a "non-fixed" facility, providing outpatient medical and dental services, primarily intended for DoD active duty. The entity is funded with other than Defense Health Program funding. Non-DoD active duty may receive services from this entity. "Non-fixed" facilities are generally deployed DoD health care activities, not providing services on or in association with a DoD fort or base. "Non-fixed" facilities include outpatient services furnished onboard ships. "Non-fixed" facilities also include deployed clinics. Does not include items issued directly to a patient from an outpatient pharmacy or patient transport.

[1/1/2005: title modified, definition added]

Effective Date 4/1/2002 Last Modified Date 1/1/2005

Specialization: Military/U.S. Coast Guard Outpatient

261QM1100X Military/U.S. Coast Guard Outpatient Clinic/Center

The Defense Health Program or U.S. Coast Guard funded "fixed" facilities or distinct parts of a facility, providing outpatient medical and dental services, primarily for Uniformed Services beneficiaries. A "fixed" facility is a non-temporary, non-deployed facility. It includes mobile specialty units such as Magnetic Resonance Imaging (MRI) units that may furnish services at the "fixed" facility. It includes, as examples, the institutional portion of outpatient encounters (except Ambulatory Procedure Visits), supplies issued (e.g., glasses, ostomy supplies, crutches), and radiology and laboratory studies. Does not include items issued directly to a patient from an outpatient pharmacy or patient transport.

Source: TRICARE Management Activity Uniform Business Office User's Guide [1/1/2005: title modified, definition added; 7/1/2006 title modified, definition modified]

Effective Date 4/1/2002 Last Modified Date 7/1/2006

Specialization: Multi-Specialty

261QM1300X Multi-Specialty Clinic/Center

Definition to come...

#Type!

Effective Date 4/1/2002

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Occupational Medicine

261QX0100X **Occupational Medicine Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Oncology

261QX0200X **Oncology Clinic/Center**

An entity, facility, or distinct part of a facility providing diagnostic, treatment and prescriptive services related to cancerous conditions. Services include chemotherapy infusions and monitoring of implanted chemotherapeutic agents.

[7/1/2003: new]

Effective Date 10/1/2003

Specialization: Oncology, Radiation

261QX0203X **Radiation Oncology Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Ophthalmologic Surgery

261QS0132X **Ophthalmologic Surgery Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Oral and Maxillofacial Surgery

261QS0112X **Oral and Maxillofacial Surgery Clinic/Center**

The specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

Source: Council on Dental Education and Licensure, American Dental Association

Effective Date 4/1/2002

Specialization: Pain

261QP3300X **Pain Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Physical Therapy

261QP2000X **Physical Therapy Clinic/Center**

An entity, facility, or distinct part of a facility providing diagnostic and treatment services related to physical rehabilitation. Physical therapy is a dynamic profession with an established theoretical and scientific base and widespread clinical applications in the restoration, maintenance, and promotion of optimal physical function. Physical therapists and physical therapist assistants are licensed health care professionals who are experts in the movement system and help individuals maintain, restore, and improve movement, activity, and functioning, thereby enabling optimal performance and enhancing health, well-being, and quality of life. Their services prevent, minimize, or eliminate impairments of body functions and structures, activity limitations, and participation restrictions. Physical therapy is provided for individuals of all ages who have or may develop impairments, activity limitations, and participation restrictions related to (1) conditions of the musculoskeletal, neuromuscular, cardiovascular, pulmonary, and/or integumentary systems or (2) the negative effects attributable to unique personal and environmental factors as they relate to human performance.

Source: Guide to PT Practice 3.0 [1/1/2020: definition added] Additional resources: http://guidetoptpractice.apta.org/ ; American Physical Therapy Association, www.apta.org.

Effective Date 4/1/2002 Last Modified Date 1/1/2020

Specialization: Podiatric

261QP1100X **Podiatric Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Primary Care

261QP2300X **Primary Care Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Prison Health

261QP2400X **Prison Health Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Public Health, Federal

261QP0904X **Federal Public Health Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Public Health, State or Local
261QP0905X **State or Local Public Health Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Radiology
261QR0200X **Radiology Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Radiology, Mammography
261QR0206X **Mammography Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Radiology, Mobile
261QR0208X **Mobile Radiology Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Radiology, Mobile Mammography
261QR0207X **Mobile Mammography Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Recovery Care
261QR0800X **Recovery Care Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Rehabilitation

261QR0400X **Rehabilitation Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Rehabilitation, Cardiac Facilities

261QR0404X **Cardiac Rehabilitation Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)

261QR0401X **Comprehensive Outpatient Rehabilitation Facility (CORF)**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Rehabilitation, Substance Use Disorder

261QR0405X **Substance Use Disorder Rehabilitation Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Research

261QR1100X **Research Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Rural Health

261QR1300X **Rural Health Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Ambulatory Health Care Facilities

Clinic/Center

Specialization: Sleep Disorder Diagnostic

261QS1200X **Sleep Disorder Diagnostic Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Student Health

261QS1000X **Student Health Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Urgent Care

261QU0200X **Urgent Care Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: VA

261QV0200X **VA Clinic/Center**

Definition to come...

#Type!

Effective Date 4/1/2002

Hospital Units

Epilepsy Unit

273100000X **Epilepsy Hospital Unit**

An Epilepsy Unit is a distinct unit of a hospital that provides services that may include observation, urgent care, diagnostic testing, treatment, and medication management for patients with seizure disorders.

Source: National Uniform Claim Committee [7/1/2007: new]

Effective Date 10/1/2007

Hospital Units

Medicare Defined Swing Bed Unit

275N00000X Medicare Defined Swing Bed Hospital Unit

A unit of a hospital that has a Medicare provider agreement and has been granted approval from HCFA to provide post-hospital extended care services and be reimbursed as a swing-bed unit.

Source: Code of Federal Regulations #42, Section 482.66.

Effective Date 4/1/2002

Psychiatric Unit

273R00000X Psychiatric Hospital Unit

In general, a distinct unit of a hospital that provides acute or long-term care to emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment of psychiatric problems on the basis of physicians' orders and approved nursing care plans. Long-term care may include intensive supervision to the chronically mentally ill, mentally disordered or other mentally incompetent persons; (2) For Medicare, a distinct part of a general acute care hospital admitting only patients whose admission to the unit is required for active treatment, whose treatment is of an intensity that can be provided only in an inpatient hospital setting, and whose condition is described by a psychiatric principal diagnosis contained in the Third Edition of the American Psychiatric Association Diagnostic and Statistical Manual or in Chapter 5 (Mental Disorders) of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). The unit must furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing, occupational therapy, and recreational therapy. The unit must maintain medical records that permit determination of the degree and intensity of treatment provided to individuals who are furnished services in the unit; the unit must meet special staff requirements in that the unit must have adequate numbers of qualified professional and supportive staff to evaluate inpatients, formulate written, individualized, comprehensive treatment plans, provide active treatment measures and engage in discharge planning.

Source: (1) AHA Annual Survey p. A10 1996 AHA Guide; (2) Code of Federal Regulations #42, Section 412.27.

Effective Date 4/1/2002

Hospital Units

Rehabilitation Unit

273Y00000X Rehabilitation Hospital Unit

In general, a distinct unit of a general acute care hospital that provides care encompassing a comprehensive array of restoration services for the disabled and all support services necessary to help patients attain their maximum functional capacity. Source: AHA Annual Survey p. A10 1996 AHA Guide. For Medicare, a distinct part of a general acute care hospital providing inpatient rehabilitation services that meets the following requirements. Rehabilitation Units have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient program or assessment; ensure that the patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy and occupational therapy, plus, as needed, speech therapy, social services or psychological services and orthotic and prosthetic services; have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient; use a coordinated multidisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and that team conferences are held at least every two weeks to determine the appropriateness of treatment; have a director of rehabilitation who provides services to the unit and its inpatients for at least 20 hours a week, is a doctor of medicine or osteopathy, is licensed under State law to practice medicine or surgery, and has had, after completing a one-year hospital internship at least two years of training or experience in the medical management of inpatients requiring rehabilitation services.

Source: Code of Federal Regulations #42, Section 412.29.

Effective Date 4/1/2002

Rehabilitation, Substance Use Disorder Unit

276400000X Substance Use Disorder Rehabilitation Hospital Unit

A distinct part of a hospital that provides medically monitored, interdisciplinary addiction-focused treatment to patients/clients who have psychoactive substance use disorders (commonly referred to as alcohol and drug abuse or substance abuse.)

Source: Department of Defense Regulation 6010.8-R, Chapter 6.

Effective Date 4/1/2002

Hospitals

Christian Science Sanitorium

287300000X Deactivated - Christian Science Sanitorium

Inactive, use 282J00000X

[7/1/2009: marked inactive]

Effective Date 4/1/2002 Deactivation Date 9/30/2009

Hospitals

Chronic Disease Hospital

281P00000X Chronic Disease Hospital

(1) A hospital including a physical plant and personnel that provides multidisciplinary diagnosis and treatment for diseases that have one or more of the following characteristics: is permanent; leaves residual disability; is caused by nonreversible pathological alteration; requires special training of the patient for rehabilitation; and/or may be expected to require a long period of supervision or care. In addition, patients require the safety, security, and shelter of these specialized inpatient or partial hospitalization settings. (2) A hospital that provides medical and skilled nursing services to patients with long-term illnesses who are not in an acute phase but who require an intensity of services not available in nursing homes.

Source: (1) Expanded from Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Specialization: Children

281PC2000X Children's Chronic Disease Hospital

Definition to come...

#Type!

Effective Date 4/1/2002

General Acute Care Hospital

282N00000X General Acute Care Hospital

An acute general hospital is an institution whose primary function is to provide inpatient diagnostic and therapeutic services for a variety of medical conditions, both surgical and non-surgical, to a wide population group. The hospital treats patients in an acute phase of illness or injury, characterized by a single episode or a fairly short duration, from which the patient returns to his or her normal or previous level of activity.

#Type!

Effective Date 4/1/2002

Specialization: Children

282NC2000X Children's Hospital

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Critical Access

282NC0060X Critical Access Hospital

Definition to come.

[7/1/2003: new]

Effective Date 10/1/2003

Hospitals

General Acute Care Hospital

Specialization: Rural

282NR1301X **Rural Acute Care Hospital**

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Women

282NW0100X **Women's Hospital**

Definition to come...

#Type!

Effective Date 4/1/2002

Long Term Care Hospital

282E00000X **Long Term Care Hospital**

Long-term care hospitals (LTCHs) furnish extended medical and rehabilitative care to individuals who are clinically complex and have multiple acute or chronic conditions.

Source: American Hospital Association [7/1/2006: new]

Effective Date 10/1/2006

Military Hospital

286500000X **Military Hospital**

A health care facility operated by the Department of Defense.

#Type!

Effective Date 4/1/2002

Specialization: Community Health

2865C1500X **Deactivated - Military Hospital**

[1/1/2005: marked inactive]

Effective Date 4/1/2002 Deactivation Date 3/31/2005

Hospitals

Military Hospital

Specialization: Military General Acute Care Hospital

2865M2000X Military General Acute Care Hospital

A Department of Defense (DoD) health care organization furnishing inpatient care 24 hours per day in "fixed" facilities, primarily for DoD beneficiaries. Entity is Defense Health Program (DHP) funded. A "fixed" facility is a non-temporary, non-deployed facility usually used for health care services. It includes mobile specialty units such as Magnetic Resonance Imaging (MRI) units that may furnish services at the "fixed" facility. It includes those services and institutional costs usually included in a Diagnosis Related Group as well as "pass-through" items.

[1/1/2005: title modified, definition added]

Effective Date 4/1/2002 Last Modified Date 1/1/2005

Specialization: Military General Acute Care Hospital. Operational (Transportable)

2865X1600X Operational (Transportable) Military General Acute Care Hospital

A Department of Defense (DoD) health care organization furnishing inpatient care 24 hours per day in "non-fixed" or deployed facilities. Entity is not Defense Health Program funded. Services are primarily intended for DoD active duty though some services may be furnished for non-DoD active duty. "Non-fixed" facilities are generally deployed DoD health care activities, not providing services on or in association with a DoD fort or base. "Non-fixed" facilities include hospital ships.

[1/1/2005: title modified, definition added]

Effective Date 4/1/2002 Last Modified Date 1/1/2005

Psychiatric Hospital

283Q00000X Psychiatric Hospital

An organization including a physical plant and personnel that provides multidisciplinary diagnostic and treatment mental health services to patients requiring the safety, security, and shelter of the inpatient or partial hospitalization settings.

Source: Expanded from Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Rehabilitation Hospital

283X00000X Rehabilitation Hospital

A hospital or facility that provides health-related, social and/or vocational services to disabled persons to help them attain their maximum functional capacity.

Source: Joint Commission on Accreditation of Healthcare Organizations, Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, Oakbrook Terrace, IL: 1994, p. 323

Effective Date 4/1/2002

Hospitals

Rehabilitation Hospital

Specialization: Children

283XC2000X **Children's Rehabilitation Hospital**

Definition to come...

#Type!

Effective Date 4/1/2002

Religious Nonmedical Health Care Institution

282J00000X **Religious Nonmedical Health Care Institution**

Furnishes only nonmedical nursing items and services to patients who choose to rely solely upon a religious method of healing, and for whom the acceptance of medical services would be inconsistent with their religious beliefs. Furnishes nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of nonmedical patients. For example, caring for the physical needs such as assistance with activities of daily living; assistance in moving, positioning, and ambulation; nutritional needs; and comfort and support measures. Furnishes nonmedical items and services to inpatients on a 24-hour basis. Does not furnish, on the basis of religious beliefs, through its personnel or otherwise, medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients.

Source: Centers for Medicare & Medicaid Services, http://www.cms.hhs.gov/CertificationandComplianc/19_RNHCIs.asp#TopOfPage [7/1/2006: new]

Effective Date 10/1/2006

Special Hospital

284300000X **Special Hospital**

A designation by the AHA of a hospital whose primary function of the institution is to provide diagnostic and treatment services for patients who have specified medical conditions, both surgical and nonsurgical.

Source: AHA Guide, Registration section, p. A5.

Effective Date 4/1/2002

Laboratories

Clinical Medical Laboratory

291U00000X Clinical Medical Laboratory

(1) A clinical laboratory is a facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered clinical laboratories. (2) Any facility that examines materials from the human body for purposes of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of, the health of human beings. Typical divisions of a clinical laboratory include hematology, cytology, bacteriology, histology, biochemistry, medical toxicology, and serology.

Source: (1) Code of Federal Regulations #42, Public Health, Section 493.2. (2)) Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 186.

Effective Date 4/1/2002

Dental Laboratory

292200000X Dental Laboratory

A commercial laboratory specializing in the construction of dental appliances that conform to a dentist's specifications including the construction of dentures (complete or partial), orthodontic appliances, bridgework, crowns, and inlays.

Source: Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 1245.

Effective Date 4/1/2002

Military Clinical Medical Laboratory

291900000X Military Clinical Medical Laboratory

A Department of Defense (DoD) medical clinical reference laboratory not associated with a DoD Hospital or DoD Clinic. An example is the Armed Forces Institute of Pathology.

[1/1/2005: new]

Effective Date 4/1/2005

Laboratories

Physiological Laboratory

293D00000X Physiological Laboratory

A laboratory that operates independently of a hospital and physician's office to furnish physiological diagnostic services (e.g. EEG's , EKG's, scans, etc.). Facilities offering ONLY physiological services are not certified as independent laboratories. If an independent laboratory offers physiological services IN ADDITION to clinical laboratory services, they are surveyed only for compliance with the clinical laboratory regulations because there are no health and safety regulations for physiological services.

Source: Paraphrased from the Medicare Carrier Manual, Section 2070.5.

Effective Date 4/1/2002

Managed Care Organizations

Exclusive Provider Organization

302F00000X Exclusive Provider Organization

(1) An EPO is a form of PPO, in which patients must visit a caregiver that is specified on its panel of providers (is a participating provider). If a visit to an outside(not participating) provider is made the EPO offers very limited or no coverage for the medical service; (2) While similar to a PPO in that an EPO allows patients to go outside the network for care, if they do so in an EPO, they are required to pay the entire cost of care. An EPO differs from an HMO in that EPO physicians do not receive capitation but instead are reimbursed only for actual services provided; (3) An organization identical to a preferred provider organization except that persons enrolled in the plan are eligible to receive benefits only when they use the services of the contracting providers. No benefits are available when non-contracting providers are used, except in certain emergency situations.

Source: (1) Medical Interface: Managed Care A thru Z- Managed Care Terms published by Medicom International, Bronxville, New York Telephone (914) 337-5023, p. 15; (2) "Glossary of terms used in managed care" Developed by the Managed Care Assembly (MCA) of Medical Group Management Association (MGMA), MGM Journal, September/October 1995, p. 58; (3) Rhea, Ott, and Shafritz, The Facts On File Dictionary of Health Care Management, New York: Facts On File Publications, 1988.

Effective Date 4/1/2002

Managed Care Organizations

Health Maintenance Organization

302R00000X Health Maintenance Organization

(1) A form of health insurance in which its members prepay a premium for the HMO's health services which generally include inpatient and ambulatory care. For the patient, an HMO means reduced out-of-pocket costs (i.e. no deductible), no paperwork (i.e. insurance forms), and only a small copayment for each office visit to cover the paperwork handled by the HMO; (2) A organization of health care personnel and facilities that provides a comprehensive range of health services to an enrolled population for a fixed sum of money paid in advance for a specified period of time. These health services include a wide variety of medical treatments and consults, inpatient and outpatient hospitalization, home health service, ambulance service, and sometimes dental and pharmacy services. The HMO may be organized as a group model, an individual practice association (IPA), a network model or a staff model.

Source: (1) Medical Interface: Managed Care A thru Z- Managed Care Terms published by Medicom International, Bronxville, New York Telephone (914) 337-5023, p. 20; (2) "Glossary of terms used in managed care" Developed by the Managed Care Assembly (MCA) of Medical Group Management Association (MGMA), MGM Journal, September/October 1995, p. 58

Effective Date 4/1/2002

Point of Service

305S00000X Point of Service

This product may also be called an open-ended HMO and offers a transition product incorporating features of both HMOs and PPOs. Beneficiaries are enrolled in an HMO but have the option to go outside the networks for an additional cost.

Source: "Glossary of terms used in managed care" Developed by the Managed Care Assembly (MCA) of Medical Group Management Association (MGMA), MGM Journal, September/October 1995, p. 62

Effective Date 4/1/2002

Preferred Provider Organization

305R00000X Preferred Provider Organization

A group of physicians and/or hospitals who contract with an employer to provide services to their employees. In a PPO, the patient may got to the physician of his/her choice, even if that physician does not participate in the PPO, but the patient receives care at a lower benefit level.

Source: "Glossary of terms used in managed care" Developed by the Managed Care Assembly (MCA) of Medical Group Management Association (MGMA), MGM Journal, September/ October 1995, p. 62

Effective Date 4/1/2002

Nursing & Custodial Care Facilities

Alzheimer Center (Dementia Center)

311500000X Alzheimer Center (Dementia Center)

A freestanding facility or special care unit of a long term care facility focusing on patient care of individuals diagnosed with dementia or Alzheimer's Disease or their related diseases. Six elements of the facility/unit set it apart from other (the rest of the) facilities(y): Admission of residents with dementia (including those with Alzheimer's disease); Staff who are specially selected, trained, and supervised; Activities that are specifically designed for the cognitively impaired; A marketing of a special care unit in brochures; A high level of family involvement; and A physical environment designed to keep residents safe and segregated from other populations.

#Type!

Effective Date 4/1/2002

Assisted Living Facility

310400000X Assisted Living Facility

A facility providing supportive services to individuals who can function independently in most areas of activity, but need assistance and/or monitoring to assure safety and well being.

[7/1/2003: new]

Effective Date 10/1/2003

Specialization: Assisted Living, Behavioral Disturbances

3104A0630X Assisted Living Facility (Behavioral Disturbances)

A facility providing supportive services to individuals who can function independently in most areas of activity, but exhibit abnormal behavioral responses and habits and therefore need special guidance, assistance and/or monitoring to assure safety and well being. This type of facility requires a staff with special training in dealing with and redirecting negative, violent or destructive behaviors.

[7/1/2003: new]

Effective Date 10/1/2003

Specialization: Assisted Living, Mental Illness

3104A0625X Assisted Living Facility (Mental Illness)

A facility providing supportive services to individuals who can function independently in most areas of activity, but need special guidance, assistance and/or monitoring as the result of a psychiatric problem. This type of facility requires a staff with special training in mental health training and dealing with psychiatric emergencies.

[7/1/2003: new]

Effective Date 10/1/2003

Christian Science Facility

317400000X Deactivated - Christian Science Facility

Inactive, use 282J00000X

[7/1/2009: marked inactive]

Effective Date 4/1/2002 Deactivation Date 9/30/2009

Nursing & Custodial Care Facilities

Custodial Care Facility

311Z00000X Custodial Care Facility

A facility providing care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel.

Source: Paraphrased from Section 3159 A3 of the Medicare Intermediary Manual.

Effective Date 4/1/2002

Specialization: Adult Care Home

311ZA0620X Adult Care Home Facility

A custodial care facility providing supportive and personal care services to disabled and/or elderly individuals who cannot function independently in most areas of activity and need assistance and monitoring to enable them to remain in a home like environment.

[7/1/2003: new]

Effective Date 10/1/2003

Hospice, Inpatient

315D00000X Inpatient Hospice

A provider organization, or distinct part of the organization, which renders an interdisciplinary program providing palliative care, chiefly medical relief of pain and supporting services, which addresses the emotional, social, financial, and legal needs of terminally ill patients and their families where an institutional care environment is required for the patient.

Source: AHA Guide, American Hospital Association.

Effective Date 4/1/2002

Intermediate Care Facility, Intellectual Disabilities

315P00000X Intellectual Disabilities Intermediate Care Facility

An intermediate care facility providing services for individuals with intellectual disabilities.

Source: Public Health, 42 CFR § 400.200 (2021)

Effective Date 4/1/2002 Last Modified Date 7/1/2022

Intermediate Care Facility, Mental Illness

310500000X Mental Illness Intermediate Care Facility

A nursing facility that provides an intermediate level of nursing care to individuals whose functional abilities are significantly compromise by mental illness.

[7/1/2003: new]

Effective Date 10/1/2003

Nursing & Custodial Care Facilities

Nursing Facility/Intermediate Care Facility

313M00000X Nursing Facility/Intermediate Care Facility

An institution (or a distinct part of an institution) which- (1) is primarily engaged in providing to residents- (A) skilled nursing care and related services for residents who require medical or nursing care, (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases; (2) has in effect a transfer agreement with one or more hospitals.

Source: Paraphrased from Section 1919 (a) of the Social Security Act.

Effective Date 4/1/2002

Skilled Nursing Facility

314000000X Skilled Nursing Facility

(1) A skilled nursing facility is a facility or distinct part of an institution whose primary function is to provide medical, continuous nursing, and other health and social services to patients who are not in an acute phase of illness requiring services in a hospital, but who require primary restorative or skilled nursing services on an inpatient basis above the level of intermediate or custodial care in order to reach a degree of body functioning to permit self care in essential daily living. It meets any licensing or certification standards et forth by the jurisdiction where it is located. A skilled nursing facility may be a freestanding facility or part of a hospital that has been certified by Medicare to admit patients requiring subacute care and rehabilitation; (2) Provides non-acute medical and skilled nursing care services, therapy and social services under the supervision of a licensed registered nurse on a 24-hour basis.

Source: (1) "Glossary of terms used in managed care" Developed by the Managed Care Assembly (MCA) of Medical Group Management Association (MGMA), MGM Journal, September/October 1995, p. 64; (2) AHA Guide, 1996 Annual Survey.

Effective Date 4/1/2002

Specialization: Nursing Care, Pediatric

3140N1450X Pediatric Skilled Nursing Facility

A nursing care facility designed and staffed for the provision of nursing care and appropriate educational and habilitative/rehabilitative services to children with multiple, complex or profound disabilities that can not be cared for in a less restrictive environment.

[7/1/2003: new]

Effective Date 10/1/2003

Other Service Providers

Lodging

177F00000X **Lodging Provider**

A public or privately owned facility providing overnight lodging to individuals traveling long distances or receiving prolonged outpatient medical services away from home.

#Type!

Effective Date 4/1/2002

Meals

174200000X **Meals Provider**

A public or privately owned facility providing meals to individuals traveling long distances or receiving prolonged outpatient medical services away from home.

Source: SD DSS Non-Emergency Medical Transportation program Transportation Services [7/1/2010: new]

Effective Date 10/1/2010

Residential Treatment Facilities

Community Based Residential Treatment Facility, Intellectual and/or Developmental Disabilities

320900000X **Intellectual and/or Developmental Disabilities Community Based Residential Treatment Facility**

A home-like residential facility providing habilitation, support and monitoring services to individuals diagnosed with intellectual and/or developmental disabilities.

[7/1/2003: new, 1/1/2021: modified title, modified definition]

Effective Date 10/1/2003 Last Modified Date 1/1/2021

Community Based Residential Treatment Facility, Mental Illness

320800000X **Mental Illness Community Based Residential Treatment Facility**

A home-like residential facility providing psychiatric treatment and psycho/social rehabilitative services to individuals diagnosed with mental illness.

[7/1/2003: new]

Effective Date 10/1/2003

Residential Treatment Facilities

Psychiatric Residential Treatment Facility

323P00000X Psychiatric Residential Treatment Facility

A residential treatment facility (RTF) is a facility or distinct part of a facility that provides to children and adolescents, a total, twenty-four hour, therapeutically planned group living and learning situation where distinct and individualized psychotherapeutic interventions can take place. Residential treatment is a specific level of care to be differentiated from acute, intermediate, and long-term hospital care, when the least restrictive environment is maintained to allow for normalization of the patient's surroundings. The RTF must be both physically and programmatically distinct if it is a part or subunit of a larger treatment program. An RTF is organized and professionally staffed to provide residential treatment of mental disorders to children and adolescents who have sufficient intellectual potential to respond to active treatment (that is, for whom it can reasonably be assumed that treatment of the mental disorder will result in an improved ability to function outside the RTF) for whom outpatient treatment, partial hospitalization or protected and structured environment is medically or psychologically necessary

Source: Champus Policy manual, Volume II, p. 6010.47M dated 9/12/94. Revision: Definition title revised 7/1/03

Effective Date 4/1/2002

Residential Treatment Facility, Emotionally Disturbed Children

322D00000X Emotionally Disturbed Childrens' Residential Treatment Facility

A residential facility that provides habilitation services and other care and treatment to children diagnosed with mental health illness, behavioral issues, and intellectual disabilities and are not able to live independently.

Source: U.S. Department of Defense Regulation 6010.8-R, Chapter 6. [1/1/2021: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2021

Residential Treatment Facility, Intellectual and/or Developmental Disabilities

320600000X Intellectual and/or Developmental Disabilities Residential Treatment Facility

A residential facility that provides habilitation services and other care and treatment to adults or children diagnosed with developmental and intellectual disabilities and are not able to live independently.

[7/1/2003: new. 1/1/2021: modified title and definition]

Effective Date 10/1/2003 Last Modified Date 1/1/2021

Residential Treatment Facility, Physical Disabilities

320700000X Physical Disabilities Residential Treatment Facility

A residential facility that provides habilitation services and other care and treatment to adults or children diagnosed with physical disabilities and are not able to live independently.

[7/1/2003: new, 1/1/2021: modified definition]

Effective Date 10/1/2003 Last Modified Date 1/1/2021

Residential Treatment Facilities

Substance Abuse Rehabilitation Facility

324500000X Substance Abuse Rehabilitation Facility

A facility or distinct part of a facility that provides a 24 hr therapeutically planned living and rehabilitative intervention environment for the treatment of individuals with disorders in the abuse of drugs, alcohol, and other substances.

[7/1/2003: modified title, modified definition]

Effective Date 4/1/2002 Last Modified Date 7/1/2003

Specialization: Substance Abuse Treatment, Children

3245S0500X Children's Substance Abuse Rehabilitation Facility

A facility or distinct part of a facility that provides a 24 hr therapeutically planned living and rehabilitative intervention environment for the treatment of children with disorders in the use of drugs, alcohol, and other substances. Medical and supportive counseling services and education services are included.

[7/1/2003: new]

Effective Date 10/1/2003

Respite Care Facility

Respite Care

385H00000X Respite Care

Definition to come.

#Type!

Effective Date 4/1/2002

Specialization: Respite Care Camp

385HR2050X Respite Care Camp

A camping facility that provides specialized respite care to individuals requiring enhanced services to enable them to remain in the community, (e.g., those with developmental delays, intellectual disabilities, mental/behavioral disorders). The staff must have training in working with the target populations and dealing with emergency situations which might be related to or exacerbate the individual's condition.

[7/1/2003: new, 1/1/2021: modified definition]

Effective Date 10/1/2003 Last Modified Date 1/1/2021

Specialization: Respite Care, Intellectual and/or Developmental Disabilities, Child

385HR2060X Child Intellectual and/or Developmental Disabilities Respite Care

A facility or distinct part of a facility that provides short term, residential care to children diagnosed with intellectual and/or developmental disabilities as respite for the regular caregivers.

[7/1/2003: new, 1/1/2021: modified definition]

Effective Date 10/1/2003 Last Modified Date 1/1/2021

Respite Care Facility

Respite Care

Specialization: Respite Care, Mental Illness, Child

385HR2055X Child Mental Illness Respite Care

A facility or distinct part of a facility that provides short term, residential care to children, diagnosed with mental illness, as respite for the regular caregivers.

[7/1/2003: new]

Effective Date 10/1/2003

Specialization: Respite Care, Physical Disabilities, Child

385HR2065X Child Physical Disabilities Respite Care

A facility or distinct part of a facility that providers short term, residential care to children, diagnosed with complex or profound disabilities as respite for the regular caregivers.

[7/1/2003: new]

Effective Date 10/1/2003

Suppliers

Blood Bank

331L00000X Blood Bank

An institution (organization or distinct part thereof) that performs, or is responsible for the performance of, the collection, processing, storage and/or issuance of human blood and blood components, intended for transfusion. The institution may also collect, process, and/or distribute human tissue, including bone marrow and peripheral blood progenitor cells, intended for transplantation.

Source: American Association of Blood Banks, Standards for Blood Banks and Tranfusion, 17th ed.

Effective Date 4/1/2002

Department of Veterans Affairs (VA) Pharmacy

332100000X Department of Veterans Affairs (VA) Pharmacy

Department of Veterans Affairs (VA) Pharmacy means any place under VA jurisdiction where drugs are dispensed and Pharmaceutical Care is provided to enrolled Veterans, by licensed pharmacists. The Pharmacy is reviewed by JCAHO, utilizes the VA hospital's DEA number, and has a designated NCPDP number. VA facility pharmacies include Inpatient (Institutional), Outpatient, Consolidated Mail Outpatient Pharmacies (CMOPs), Research, Addiction Treatment Centers, Long Term Care and Community Based Outpatient Clinics Pharmacies. The VHA Pharmacy Benefits Management - Strategic Healthcare Group has oversight for professional and practice activities of VA Pharmacies. Each pharmacy is under the direct supervision of a U.S. or U.S. territory licensed pharmacist, and has staffing to meet its designated scope of service.

Source: Pharmacy Benefits Management - Strategic Healthcare Group, Veterans Health Administration, Department of Veterans Affairs [1/1/2006: new]

Effective Date 4/1/2006

Suppliers

Durable Medical Equipment & Medical Supplies

332B00000X Durable Medical Equipment & Medical Supplies

A supplier of medical equipment such as respirators, wheelchairs, home dialysis systems, or monitoring systems, that are prescribed by a physician for a patient's use in the home and that are usable for an extended period of time.

#Type!

Effective Date 4/1/2002

Specialization: Customized Equipment

332BC3200X Customized Equipment (DME)

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Dialysis Equipment & Supplies

332BD1200X Dialysis Equipment & Supplies (DME)

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Nursing Facility Supplies

332BN1400X Nursing Facility Supplies (DME)

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Oxygen Equipment & Supplies

332BX2000X Oxygen Equipment & Supplies (DME)

Definition to come...

#Type!

Effective Date 4/1/2002

Specialization: Parenteral & Enteral Nutrition

332BP3500X Parenteral & Enteral Nutrition Supplies (DME)

Definition to come...

#Type!

Effective Date 4/1/2002

Suppliers

Emergency Response System Companies

333300000X Emergency Response System Companies

A supplier of a personal emergency response system (PERS), which is an electronic device that enables a patient to receive emergency assistance when needed. The PERS is one of two different methodologies of notification: (1) where the patient summons emergency assistance themselves directly through the device or (2) emergency assistance is summoned through secure activation by the caretaker/guardian, which sends the device location to emergency responders.

Source: National Uniform Claim Committee, 2010 [7/1/2007: new, 7/1/2010: modified]

Effective Date 10/1/2007

Eye Bank

332G00000X Eye Bank

An eye bank procures and distributes eyes for transplant, education and research. To promote patient safety, donated eyes and donor medial histories are evaluated based on strict Eye Bank Association of America Medical Standards

#Type!

Effective Date 4/1/2002

Eyewear Supplier

332H00000X Eyewear Supplier

An organization that provides spectacles, contact lenses, and other vision enhancement devices prescribed by an optometrist or ophthalmologist.

#Type!

Effective Date 4/1/2002

Hearing Aid Equipment

332S00000X Hearing Aid Equipment

The manufacture and/or sale of electronic hearing aids, their component parts, and related products and services on a national basis.

#Type!

Effective Date 4/1/2002

Home Delivered Meals

332U00000X Home Delivered Meals

Home-delivered meals are those services or activities designed to prepare and deliver one or more meals a day to an individual's residence in order to prevent institutionalization, malnutrition, and feelings of isolation. Component services or activities may include the cost of personnel, equipment, and food; assessment of nutritional and dietary needs; nutritional education and counseling; socialization services; and information and referral.

Source: Code of Federal Regulations #45, Part 96, Appendix A, Uniform Definition of Services.

Effective Date 4/1/2002

Suppliers

Indian Health Service/Tribal/Urban Indian Health (I/T/U) Pharmacy

332800000X Indian Health Service/Tribal/Urban Indian Health (I/T/U) Pharmacy

An Indian Health Service/Tribal/Urban Indian Health (I/T/U) Pharmacy means a pharmacy operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization, all of which are defined in Section 4 of the Indian Health Care Improvement Act, 25 U.S.C. 1603.

Source: The Medicare Prescription Drug, Improvement and Modernization Act of 2003 [1/1/2006: new]

Effective Date 4/1/2006

Medical Foods Supplier

335G00000X Medical Foods Supplier

A supplier of special replacement foods for clients with errors of metabolism that prohibit them from eating a regular diet. Medical foods are lacking in the compounds which cause complications of the metabolic disorder, and are not generally available in grocery stores, health food stores, or pharmacies.

Source: The Children with Special Healthcare Needs (CSHCN) Services Program, a program of the Texas Department of State Health Services [10/1/2011: new]

Effective Date 10/1/2011

Military/U.S. Coast Guard Pharmacy

332000000X Military/U.S. Coast Guard Pharmacy

A Department of Defense (DoD) or U.S. Coast Guard entity whose primary function is to store, prepare and dispense pharmaceuticals and other associated items to Uniformed Services beneficiaries. These pharmacies may be associated with a DoD or U.S. Coast Guard clinic, DoD Hospital or freestanding. Usually associated with outpatient services.

Source: TRICARE Management Activity Uniform Business Office User's Guide [1/1/2005: new; 7/1/2006: modified title, modified definition]

Effective Date 4/1/2005 Last Modified Date 7/1/2006

Non-Pharmacy Dispensing Site

332900000X Non-Pharmacy Dispensing Site

A site other than a pharmacy that dispenses medicinal preparations under the supervision of a physician to patients for self-administration. (e.g. physician offices, ER, Urgent Care Centers, Rural Health Facilities, etc.)

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: new]

Effective Date 4/1/2006

Suppliers

Organ Procurement Organization

335U00000X Organ Procurement Organization

A federally designated organization that works with hospital personnel in retrieval of organs for transplantation. The federal government designates an OPO's service area and the hospitals with which an OPO is to establish working relationships.

#Type!

Effective Date 4/1/2002

Pharmacy

333600000X Pharmacy

A facility used by pharmacists for the compounding and dispensing of medicinal preparations and other associated professional and administrative services. A pharmacy is a facility whose primary function is to store, prepare and legally dispense prescription drugs under the professional supervision of a licensed pharmacist. It meets any licensing or certification standards set forth by the jurisdiction where it is located.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: added definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2006

Specialization: Clinic Pharmacy

3336C0002X Clinic Pharmacy

A pharmacy in a clinic, emergency room or hospital (outpatient) that dispenses medications to patients for self-administration under the supervision of a pharmacist.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: new]

Effective Date 4/1/2006

Specialization: Community/Retail Pharmacy

3336C0003X Community/Retail Pharmacy

A pharmacy where pharmacists store, prepare, and dispense medicinal preparations and/or prescriptions for a local patient population in accordance with federal and state law; counsel patients and caregivers (sometimes independent of the dispensing process); administer vaccinations; and provide other professional services associated with pharmaceutical care such as health screenings, consultative services with other health care providers, collaborative practice, disease state management, and education classes.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: new]

Effective Date 4/1/2006

Suppliers

Pharmacy

Specialization: Compounding Pharmacy

3336C0004X Compounding Pharmacy

A pharmacy that specializes in the preparation of components into a drug preparation as the result of a Practitioner's Prescription Drug Order or initiative based on the Practitioner/Patient/Pharmacist relationship in the course of professional practice. A compounding pharmacy utilizes specialized equipment and specially designed facilities necessary to meet the legal and quality requirements of its scope of compounding practice.

Sources: NABP Model Practice Act, Appendix C - Good Compounding Practice, USP <795> and <797>, and Pharmacy Compounding Accreditation Board [7/1/2006: new]

Effective Date 10/1/2006

Specialization: Home Infusion Therapy Pharmacy

3336H0001X Home Infusion Therapy Pharmacy

Pharmacy-based, decentralized patient care organization with expertise in USP 797-compliant sterile drug compounding that provides care to patients with acute or chronic conditions generally pertaining to parenteral administration of drugs, biologics and nutritional formulae administered through catheters and/or needles in home and alternate sites. Extensive professional pharmacy services, care coordination, infusion nursing services, supplies and equipment are provided to optimize efficacy and compliance.

Source: National Home Infusion Association [1/1/2006: new]

Effective Date 4/1/2006

Specialization: Institutional Pharmacy

3336I0012X Institutional Pharmacy

A pharmacy in a hospital (inpatient) or institution used by pharmacists for the compounding and delivery of medicinal preparations to be administered to the patient by nursing or other authorized personnel. Institutional Pharmacies also counsel patients and caregivers; administer vaccinations; and provide other professional services associated with pharmaceutical care such as health screenings, consultative services with other health care providers, collaborative practice, disease state management, and education classes.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: new]

Effective Date 4/1/2006

Specialization: Long Term Care Pharmacy

3336L0003X Long Term Care Pharmacy

A pharmacy that dispenses medicinal preparations delivered to patients residing within an intermediate or skilled nursing facility, including intermediate care facilities, hospice, assisted living facilities, group homes, and other forms of congregate living arrangements.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC)

Effective Date 4/1/2006 Last Modified Date 7/1/2022

Suppliers

Pharmacy

Specialization: Mail Order Pharmacy

3336M0002X Mail Order Pharmacy

A pharmacy where pharmacists compound or dispense prescriptions or other medications in accordance with federal and state law, using common carriers to deliver the medications to patient or their caregivers. Mail order pharmacies counsel patients and caregivers (sometimes independent of the dispensing process) through telephone or email contact and provide other professional services associated with pharmaceutical care appropriate to the setting. Mail order pharmacies are licensed as a Mail Order Pharmacy in the state where they are located and may also be licensed or registered as nonresident pharmacies in other states.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: new]

Effective Date 4/1/2006

Specialization: Managed Care Organization Pharmacy

3336M0003X Managed Care Organization Pharmacy

A pharmacy owned by a managed care organization (MCO) used by pharmacists for the compounding and dispensing of medicinal preparations to that MCO's covered members only.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: new]

Effective Date 4/1/2006

Specialization: Nuclear Pharmacy

3336N0007X Nuclear Pharmacy

A pharmacy dedicated to the compounding and dispensing of radioactive materials for use in nuclear imaging and nuclear medical procedures.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: new]

Effective Date 4/1/2006

Specialization: Specialty Pharmacy

3336S0011X Specialty Pharmacy

A pharmacy that dispenses generally low volume and high cost medicinal preparations to patients who are undergoing intensive therapies for illnesses that are generally chronic, complex and potentially life threatening. Often these therapies require specialized delivery and administration.

Source: Developed by National Council for Prescription Drug Programs (NCPDP), National Home Infusion Association (NHIA), and Pharmacist Services Technical Advisory Coalition (PSTAC) [1/1/2006: new]

Effective Date 4/1/2006

Suppliers

Portable X-ray and/or Other Portable Diagnostic Imaging Supplier

335V00000X Portable X-ray and/or Other Portable Diagnostic Imaging Supplier

A supplier that provides one or more of the following portable services, including but not limited to, x-ray, electrocardiogram (EKG), long-term EKG (Holter Monitor), bone densitometry, sonography, and other imaging services in accordance with all state and federal requirements, under the general supervision of a qualified physician. All necessary resources are transported to the patient's location where the services are performed.

Source: National Uniform Claim Committee, 2015 [1/1/2016: title and definition modified]

Effective Date 4/1/2002 Last Modified Date 1/1/2016

Prosthetic/Orthotic Supplier

335E00000X Prosthetic/Orthotic Supplier

An organization that provides prosthetic and orthotic care which may include, but is not limited to, patient evaluation, prosthesis or orthosis design, fabrication, fitting and modification to treat limb loss for purposes of restoring physiological function and/or cosmesis or to treat a neuromusculoskeletal disorder or acquired condition.

Source: American Board for Certification in Orthotics, Prosthetics, and Pedorthics, Inc. [7/1/2010: modified, 7/1/2013: modified] Additional Resources: American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc., www.abcop.org and Board of Certification/Accreditation, International, www.bocusa.org.

Effective Date 4/1/2002 Last Modified Date 7/1/2013

Transportation Services

Air Carrier

344800000X Air Carrier

An air company that the Federal Aviation Administration, the certificate-holding district office (CHDO), regional Flight Standards Division (RFSD) offices, and AFS-900 has verified that the company is capable of operating safely and that it complies with the regulations and standards prescribed by the Administrator.

Source: Federal Aviation Administration [1/1/2010: new] Additional Resources: www.faa.gov/about/initiatives/atos/air_carrier/intro_to_part121_cert/

Effective Date 4/1/2010

Transportation Services

Ambulance

341600000X Ambulance

An emergency vehicle used for transporting patients to a health care facility after injury or illness. Types of ambulances used in the United States include ground (surface) ambulance, rotor-wing (helicopter), and fixed-wing aircraft (airplane).

Source: Lexikon: Dictionary of Health Care Terms, Organizations and Acronyms for the Era of Reform, The Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, Illinois: 1994, p. 37.

Effective Date 4/1/2002

Specialization: Air Transport

3416A0800X Air Ambulance

Definition to come...

[1/1/2005: title modified]

Effective Date 4/1/2002 Last Modified Date 1/1/2005

Specialization: Land Transport

3416L0300X Land Ambulance

Definition to come...

[1/1/2005: title modified]

Effective Date 4/1/2002 Last Modified Date 1/1/2005

Specialization: Water Transport

3416S0300X Water Ambulance

Definition to come...

[1/1/2005: title modified]

Effective Date 4/1/2002 Last Modified Date 1/1/2005

Bus

347B00000X Bus

A public or private organization or business licensed to provide bus services.

#Type!

Effective Date 4/1/2002

Military/U.S. Coast Guard Transport

341800000X Military/U.S. Coast Guard Transport,

Definition to come...

[1/1/2005: new; 7/1/2006 title modified]

Effective Date 4/1/2005 Last Modified Date 7/1/2006

Transportation Services

Military/U.S. Coast Guard Transport

Specialization: Military or U.S. Coast Guard Ambulance, Air Transport

3418M1120X **Military or U.S. Coast Guard Air Transport Ambulance**

Vehicle and staff for patient emergency or non-emergency air transport.

Source: TRICARE Management Activity Uniform Business Office User's Guide [1/1/2005: new; 7/1/2006 modified title, added source]

Effective Date 4/1/2005 Last Modified Date 7/1/2006

Specialization: Military or U.S. Coast Guard Ambulance, Ground Transport

3418M1110X **Military or U.S. Coast Guard Ground Transport Ambulance**

Vehicle and staff for patient emergency or non-emergency ground transport. Includes traditional ambulances as well as ambulance buses.

Source: TRICARE Management Activity Uniform Business Office User's Guide [1/1/2005: new; 7/1/2006 modified title, added source]

Effective Date 4/1/2005 Last Modified Date 7/1/2006

Specialization: Military or U.S. Coast Guard Ambulance, Water Transport

3418M1130X **Military or U.S. Coast Guard Water Transport Ambulance**

Vehicle and staff for patient emergency or non-emergency sea/water transport

Source: TRICARE Management Activity Uniform Business Office User's Guide [1/1/2005: new; 7/1/2006 modified title, added source]

Effective Date 4/1/2005 Last Modified Date 7/1/2006

Non-emergency Medical Transport (VAN)

343900000X **Non-emergency Medical Transport (VAN)**

A land vehicle with a capacity to meet special height, clearance, access, and seating, for the conveyance of persons in non-emergency situations. The vehicle may or may not be required to meet local county or state regulations.

#Type!

Effective Date 4/1/2002

Private Vehicle

347C00000X **Private Vehicle**

An individual paid to provide non-emergency transportation using their privately owned/leased vehicle.

#Type!

Effective Date 4/1/2002

Transportation Services

Secured Medical Transport (VAN)

343800000X Secured Medical Transport (VAN)

A public or privately owned transportation service with vehicles, specially equipped to provide enhanced safety, security and passenger restraint, and staffed by one or more individuals trained to work with patients in crisis situations resulting from mental or emotional illness and/or substance abuse.

#Type!

Effective Date 4/1/2002

Taxi

344600000X Taxi

A land commercial vehicle used for the transporting of persons in non-emergency situations. The vehicle meets local, county or state regulations set forth by the jurisdictions where it is located.

#Type!

Effective Date 4/1/2002

Train

347D00000X Train

An organization or business licensed to provide passenger train service, including light rail, subway, and traditional services.

#Type!

Effective Date 4/1/2002

Transportation Broker

347E00000X Transportation Broker

An organization that provides transportation for individuals who need access to medical care or services and have no other means of transportation. Transportation includes, but is not limited to, wheelchair van, taxi, stretcher car, bus passes and tickets, and secured transportation.

Source: Section 6083 of the Deficit Reduction Act of 2005 [1/1/2021: modified definition]

Effective Date 4/1/2002 Last Modified Date 1/1/2021

Transportation Network Company

342000000X Transportation Network Company

A ride-sharing company that provides prearranged or contracted non-emergency medical transportation services to patients through mobile or online technology.

Source: National Uniform Claim Committee, www.nucc.org [1/1/2021: new]

Effective Date 4/1/2021

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

11. Approve New CalOptima Health Policy AA.1251: Diversity, Equity, and Inclusion Training Program

Contacts

Michaell Rose, Chief Health Equity Officer, (657) 235-6757
Marie Jeannis, RN, MSN, CCM, Executive Director, Equity and Community Health, (714) 246-8591

Recommended Action

Approve new CalOptima Health Policy AA.1251: Diversity, Equity, and Inclusion Training Program, in accordance with regulatory requirements.

Background

In September 2023, DHCS released All-Plan Letter 23-025: Diversity, Equity, and Inclusion Training Program Requirements (APL 23-025). In the APL 23-025, DHCS emphasized its support for a multi-approach vision to advancing health equity for all Medi-Cal members. One of the requirements of managed care plans (MCPs) in support of DHCS's effort is to establish a Diversity, Equity, and Inclusion (DEI) training program.

The DEI training program must aim to create an inclusive environment among the MCP organization and staff, network providers, and community-based organizations to improve access and health outcomes through culturally competent care. Culturally competent care involves understanding and addressing cultural factors that influence health beliefs and behaviors to improve trust with members and reduce health disparities.[1]

The DEI training program must also be evidence based, include best practices, and be developed to meet the individualized needs of the members served by the MCP.

Discussion

CalOptima Health establishes new policies and procedures to implement federal and state laws and regulations, contracts, and business practices. Additionally, CalOptima Health staff performs annual policy reviews to add or update internal procedures to ensure compliance with applicable requirements.

CalOptima Health developed Policy AA.1251: Diversity, Equity, and Inclusion Training Program to comply with requirements of APL 23-025. The purpose of the new policy is to describe the CalOptima

[1] *DHCS All Plan Letter 23-025: Diversity, Equity, and Inclusion Training Program Requirements*

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Health DEI Training Program, outline oversight and continuous evaluation processes, and ensure that all CalOptima Health employees, subcontractors, downstream subcontractors, and network providers are informed and trained on DEI regulatory standards.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2024-25 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, staff recommends that the CalOptima Health Board of Directors approve and adopt CalOptima Health Policy AA.1251: Diversity, Equity, and Inclusion Training Program.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Policy AA.1251 Diversity, Equity and Inclusion Training

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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Policy:	AA.1251p
Title:	**Diversity, Equity, and Inclusion Training Program**
Department:	Equity and Community Health
Section:	Not Applicable
CEO Approval:	
Effective Date:	12/05/2024
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☒ Administrative

I. PURPOSE

This policy describes CalOptima Health's Diversity Equity, and Inclusion (DEI) Training program and ensures that all CalOptima Health Employees, Subcontractors, Downstream Subcontractors, and Network Providers, are informed and trained on DEI including standards for sensitivity, diversity, Cultural Competency and cultural humility and Health Equity training programs. This training program is in accordance with applicable Department of Health Care Services (DHCS) requirements, National Committee for Quality Assurance (NCQA) Health Equity Accreditation Standards, and Centers for Medicare & Medicaid Services (CMS) requirements.

II. POLICY

A. CalOptima Health's Chief Health Equity Officer (CHEO) shall oversee the DEI training program and ensure that all CalOptima Health Employees, as well as Subcontractors, Downstream Subcontractors and Network Providers, receive the mandatory DEI training.

1. The CHEO shall review all training materials to ensure content is up-to-date, evidence based and includes best practices for serving Members that are specific to CalOptima Health's service area of Orange County.

2. The CHEO will conduct an annual evaluation, or on a more frequent basis, as necessary, for evolving best practices of its DEI education and Training program by using the following strategies:

   a. Identifying opportunities for education and Training based on analysis of health outcomes impacted by cultural and linguistic factors;

   b. Specifically addressing training deficiencies found in the health care delivery system with educational solutions;

   c. Instituting methods to partner with and collaborate with community-based organizations that work with diverse communities for appraisal of educational efforts;

   d. Involving community leadership and decision-makers, including those with lived experience, in the design and development of education evaluation programs; and

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e. Engaging with CalOptima Health's Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) for continued DEI Training program recommendations and feedback for consideration

B. CalOptima Health shall ensure that all CalOptima Health Employees and all Network Providers, regardless of their cultural or professional training and background, who interact with CalOptima Health Members receive sensitivity, diversity, Cultural Competency and cultural humility, DEI, and bias training in accordance with the CalOptima Health Contract with DHCS for Medi-Cal.

C. Training must be specific to CalOptima Health's Member demographics in Orange County including but not limited to Members' sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical ability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in California Penal Code Section 422.56, within specific regions.

D. CalOptima Health will implement comprehensive ongoing DEI Training for all Employees on an annual basis, and in accordance with CalOptima Health Policy EE.1103: Provider Network Training shall require all Subcontractors, Downstream Subcontractors, and Network Providers to participate in online DEI Training during times of re-credentialing or contract renewals, inclusive of the following topics:

1. Sensitivity;

2. Cultural Competency and cultural humility;

3. DEI;

4. Member experience, including discrimination and the impacts of implicit bias;

5. Explicit consideration and acknowledgement of structural and institutional racism and health inequities, and their impact on Members, Employees, Network Providers, Subcontractors, and Downstream Subcontractor;

6. Information about relevant health inequities and identified cultural groups in CalOptima Health's service area, which includes but is not limited to:

   a. Seniors and Persons with Disabilities population (SPD);

   b. Those with chronic conditions;

   c. Those with specialty mental health service and/or substance use disorder needs;

   d. Those with intellectual and developmental disabilities;

   e. Children with special health care needs;

   f. The groups' beliefs about illness and health; and

   g. Lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more (LGBTQIA+) concerns, including asking for and respecting the name and pronouns Members and family members use and avoiding assumptions about partners, spouses, children and health behaviors.

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7. Need for gender affirming care;

8. Methods of interacting with Providers and the health care structure;

9. Traditional home remedies, alternative and complementary treatment that may impact how the Provider should treat the Member; and

10. Language, communication and literacy needs.

E. CalOptima Health's DEI Training program shall incorporate:

1. Accommodation of different learning styles (e.g., visual, auditory, or written) and strategies to promote motivation and incentives to integrate concepts into practice and behavior change;

2. Components to the training should allow for observational assessments and evaluation strategies;

3. Community input and advisement on development of the training as well as relevant issues, barriers, and discrimination within specific CalOptima Health service locations;

4. Development of a process for evaluating and determining the need for special initiatives regarding material to be included in the DEI Training program;

5. Recruitment and retention of staffing that represents the community served, are responsive to the community needs, and dedicated staff who apply the DEI Training program principles;

6. Assessment of Employees, Subcontractors, Downstream Subcontractors, and Network Providers for incorporating DEI Training goals into their interactions with Members and Employees with lived experience;

7. Designated staff for coordinating and facilitating the integration of DEI Training guidelines.

8. Establishment of an array of communication tools for distributing information to Employees, Subcontractors, Downstream Subcontractors, and Network Providers;

9. Participation with government, community and educational institutions in matters related to best practices encompassing the principles of DEI Training so that they may be integrated into CalOptima Health's specific DEI training program;

10. Evaluation of the effectiveness of the DEI Training program strategies for improving the health status of diverse populations with applicable alterations to the DEI Training; and

11. Provision of training in multiple formats (e.g.; braille, large print, audio, translations, etc.) as requested by Employees, Subcontractors, Downstream Subcontractors, and Network Providers.

F. In accordance with CalOptima Health Policy GG.1667: CalAIM Population Health Management Program, CalOptima Health shall address the impact of structural and institutional racism and health inequities on Members, Employees, Network Providers, Subcontractors, and Downstream Subcontractors and communicate pertinent information regarding the Population Needs Assessment (PNA) findings and identified targeted strategies.

G. CalOptima Health shall retain Training records for a period of at least ten (10) years.

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H. CalOptima Health shall make Training materials and resources available to all Employees via CalOptima Health's learning management system (LMS) and related Training sources.

I. CalOptima Health shall ensure Network Providers, Subcontractors and Downstream Subcontractors receive Training in accordance with CalOptima Health Policy EE.1103: Provider Network Training.

J. Quality Improvement and Health Equity:

1. Annually, CalOptima Health will inform the Quality Improvement and Health Equity Committee (QIHEC) of this DEI Training program with reports that include at a minimum:

   a. Training program materials;

   b. Compliance reports and;

   c. Any adjustments made to the original Training program.

2. The CHEO shall incorporate the DEI Training program within the Quality Improvement and Health Equity Transformation Program (QIHETP) goals for quality improvement and Health Equity projects pertaining to cultural needs of the Members.

   a. The CHEO shall integrate components of DEI Training priorities in the QIHETP allowing Members to assess whether CalOptima Health meets their culturally and linguistically diverse needs.

3. CalOptima Health shall conduct DEI Training program evaluation with ongoing quality improvement programs.

K. CalOptima Health shall:

1. Evaluate of Employees and Member grievances and complaints regarding discrimination, cultural biases, or insensitive practices; Evaluate Member's language access services to include written and oral interpretation services and the ability to request auxiliary aids for both in-person office visits and telehealth visits;

2. Evaluate Member satisfaction regarding culturally competent care;

3. Monitor any actions taken by the United States Equal Employment Opportunity Commission regarding discriminatory practices by medical groups and other Subcontractors;

4. In accordance with CalOptima Health Policies GG.1613: Initial Health Appointment and GG.1667: CalAIM Population Health Management Program, CalOptima Health shall Identify health care needs of diverse Members, and conduct assessments to monitor the effectiveness of health care services; and

5. Maintain information on CalOptima Health's quality performance upon request to Members in a format that is easily understood.

III. PROCEDURE

A. On an annual basis, CalOptima Health shall send an email notification to all Employees, Network Providers, Subcontractors and Downstream Subcontractors regarding the annual awareness and sensitivity, Cultural Competency and cultural humility, DEI and bias Training. The notification

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shall inform CalOptima Health Employees, Network Providers, Subcontractors and Downstream Subcontractors of the following:

1. Requirements regarding Training;

2. Location of Training module(s);

3. Instructions for completion of Training;

4. Training deadline; and

5. Contact number for questions related to the Training.

B. CalOptima Health shall run a report prior to the Training deadline to identify those who have completed the mandatory Training. Those who have not completed the Training shall be notified via email to remind them to take the required Training by the deadline.

C. Newly hired Employees will be assigned the Training upon hire. Completion is required within ninety (90) days of start date.

1. Employees failing to complete the assigned Training in the required time period shall be subject to system shutdowns, as outlined in compliance training desktop procedures, and possible corrective action, in accordance with CalOptima Health Policy GA.8022: Performance and Behavior Standards.

D. CalOptima Health participating Network Providers shall ensure Training is completed in accordance with CalOptima Health Policy EE.1103: Provider Network Training.

1. The Office of Compliance shall be responsible for taking appropriate corrective actions in response to reported issues of noncompliance, in accordance with CalOptima Health's Policies HH.2002: Sanctions and HH.2005: Correction Action Plan.

E. CalOptima Health shall coordinate DEI Training with other MCPs located in the same county.

1. CalOptima Health and other MCP's Health Equity Officers within the county shall collaborate on DEI Training criteria to ensure alignment and accurate Training record.

F. CalOptima shall develop a system of communication to ensure coordination and dissemination of cultural and linguistic information and activities to Employees, Subcontractors, Downstream Subcontractors, and Network Providers.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Penal Code, §422.56
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health Policy EE.1103: Provider Network Training
E. CalOptima Health Policy GA.8022: Performance and Behavior Standards

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F. CalOptima Health Policy GG.1613: Initial Health Appointment
G. CalOptima Health Policy GG.1667: CalAIM Population Health Management Program
H. CalOptima Health Policy HH.2002: Sanctions
I. CalOptima Health Policy HH.2005: Corrective Action Plan
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-025: Diversity, Equity, and Inclusion Training Program Requirements (Supersedes APL 99-005)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
TBD	Department of Health Care Services (DHCS)	TBD

VII. BOARD ACTION(S)

Date	Meeting
12/05/2024	Regular Meeting of CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/05/2024	AA.1251	Diversity, Equity, and Inclusion Training Program	Medi-Cal OneCare PACE Administrative

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IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Cultural Competency	The ability to actively apply knowledge of cultural behavior and linguistic issues when interacting with Members from diverse cultural and linguistic backgrounds. Essential elements of Cultural Competency include: 1. An unbiased attitude and organizational policy that values and respects cultural diversity and respect for the multifaceted nature and individuality of Members; 2. Awareness that culture and cultural beliefs may influence health and health care delivery; knowledge about, and respect for diverse attitudes, beliefs, behaviors, and practices about preventive health, illness and diseases, as well as differing communication patterns; 3. Recognition of the diversity among Members (e.g., religion, socioeconomic status, physical or mental ability, age, gender, sexual orientation, social and historical context, generational, and acculturation status); 4. Skills to communicate effectively with diverse Member populations and application of those skills in cross-cultural interactions to ensure equal access to quality health care; 5. Knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, sexual orientation, age, or disability; 6. Programs and policies that address the health needs of diverse Member populations; and 7. Ongoing program and service delivery evaluation with regard to cultural and linguistic needs of Members.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Downstream Subcontractor	An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
Employee	All employees of CalOptima Health, including all permanent and temporary employees, volunteers, and other employed personnel.
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.
Network Provider	For purposes of this policy, a Provider that is contracted with CalOptima Health or a Health Network contracted with CalOptima Health for the delivery of Covered Services.
Population Needs Assessment (PNA)	An evaluation which identifies Member health status and behaviors, Member health education and C&L needs, health disparities, and gaps in services related to these issues.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.

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Term	Definition
Subcontractor	An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.
Training	Content delivered or deployed in the following manner as appropriate to the content and audience: 1. Internal communication tools (newsletters, emails, etc.); 2. Job Aids; 3. Face-to-face delivery; 4. Webinar Training; 5. Online content deployed on CalOptima Health University 6. CalOptima Health's InfoNet; 7. CalOptima Health's website Provider Portal; 8. Online content for posting on provider group or partner website for Downstream education; and 9. Train-the-Trainer.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

12. Approve Actions Related to a New CalOptima Health Policy GG.1668: Inpatient Interfacility Transfers

Contacts

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Zeinab Dabbah, M.D., J.D., Deputy Chief Medical Officer, (714) 867-9657

Recommended Action

Approve new CalOptima Health Policy GG.1668: Inpatient Interfacility Transfers, effective December 5, 2024.

Background

The California Code of Regulations Tit. 22, § 97520.13 - Patient Transfer requires facilities to have written transfer procedures to govern both scheduled and emergency transfers. The Centers for Medicare & Medicaid Services defines an acute care transfer as the discharge of an inpatient individual from one hospital and re-admittance of that individual to another hospital, when the readmission is related to the initial discharge. Interfacility transfer policies and procedures address who is responsible for making transfer decisions, who shall make the actual transfer arrangements, and general guidelines for transfers. Interfacility transfer policies and procedures also require appropriate medical records, including complete and accurate patient information in sufficient detail to provide continuity of care and accompany the patient upon transfer.

Discussion

Staff, with the assistance of outside general legal counsel, drafted the policy to ensure its provisions align with state statutory and regulatory requirements. Staff seeks Board of Directors' approval of the attached new CalOptima Health Policy GG.1668, effective December 5, 2024.

The new policy outlines coverage criteria for medically and not medically necessary interfacility transfers, what qualifies and does not qualify as an interfacility transfer, prior authorization requirements, coordination of care standards, and claims processing. The policy ensures the safe and appropriate coordination of care for interfacility transfers are carried out based on the members' medical needs and not for convenience. In addition, the policy also ensures timely access and availability of health professionals for medically necessary determinations.

Fiscal Impact

The recommended action is operational in nature and is supported within the current CalOptima Health Fiscal Year 2024-25 Operating Budget.

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Rationale for Recommendation

Approval of the new policy GG.1668: Inpatient Interfacility Transfers is recommended to ensure compliance with law and enhance the efficiency and clarity of CalOptima Health's operations and governance related to inpatient interfacility transfer of members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

Attachment 1: New CalOptima Health Policy GA.1668: Inpatient Interfacility Transfers Packet

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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Policy:	GG.1668
Title:	**Inpatient Interfacility Transfers**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	
Effective Date:	12/05/2024
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy outlines the Interfacility Transfer of a Member who is an admitted inpatient from one acute care Facility to another acute care Facility and admitted as an inpatient.

This policy does not address transfers from the Emergency Department (ED) for Emergency Medical Treatment and Active Labor Act (EMTALA) according to Section 1867 of the Social Security Act (42 U.S. Code § 1395dd) or transfers to Facilities such as sub-acute, Long-Term Acute Care Hospitals (LTACH), Acute Rehabilitation Facilities (ARF), or Skilled Nursing Facilities (SNF).

II. POLICY

A. CalOptima Health shall provide coverage for Interfacility Transfers when one or more of the following Medical Necessity criteria has been met:

1. The Member requires a level of care (i.e., a neonatal care unit or level 1 trauma center) which is not available at the Originating Facility;

2. The Member requires the services of a specialist to evaluate, diagnose or treat the Member's condition when that specialist is not available at the Originating Facility;

3. The Member has received care at a specific prior institution for a condition not normally managed at the Originating Facility (i.e. organ transplant recipients). A transfer is needed to the prior institution to diagnose, manage, or treat a complication or other acute issue related to the prior admission; or

4. At the request of the treating Provider to meet specific medical condition unique to the Member after a peer-to-peer discussion.

B. Not Medically Necessary:

1. Interfacility Transfers are not considered Medically Necessary when:

a. Medical Necessity criteria has not been met as outlined in Section II.A. of this policy; or

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b. The Interfacility Transfer is primarily for the convenience of the individual, the individual's family, the physician, or the Originating Facility.

2. Admission and subsequent care at the receiving facility is considered not Medically Necessary when:

a. Medical Necessity criteria has not been met as outlined in Section II.A. of this policy; or

b. The Interfacility Transfer is primarily for the convenience of the individual, the individual's family, the physician or the Originating Facility.

C. A Prior Authorization is required for Transfer Back to the Originating Facility when all the following criteria are met:

1. Higher level of care needs met;

2. Medically stable;

3. Originating Facility will be able to safely continue ongoing care;

4. The Member or Member's Authorized Representative consents to transfer back to the Originating Facility; and

5. Copy of Take Back Agreement (TBA).

D. CalOptima Health requires the following for each Interfacility Transfer that has met Medical Necessity criteria as mentioned in Section II.A. of this policy. Each Facility performing the transfer is responsible for ensuring the following coordination-of-care standards listed below are performed:

1. Member receives all necessary transitional care services with a documented Plan of Care;

2. Implement a standardized discharge risk assessment;

3. Obtain permission from Members or Authorized Representatives to share information;

4. Medication reconciliation is conducted pre-and post-transition;

5. All Prior Authorizations are timely processed;

6. Hospitals educate its staff on services and supplies requiring Prior Authorization;

7. Establish mutually agreed-upon policies and procedures for transitional care services;

8. Prevent delayed transfers;

9. Each Member is evaluated for all appropriate care settings; and

10. Members with Substance Use Disorder (SUD) and mental health needs receive treatment upon discharge and/or referred to the appropriate resources.

E. Patient transfers will not be predicated on arbitrary, capricious, or unreasonable discrimination because of race, color, religion, national origin, age, sex, physical condition, disability, sexual orientation, gender identity or expression, genetic information, veteran status, economic or insurance status, or ability to pay.

III. PROCEDURE

A. CalOptima Health and its Health Networks that are responsible for Utilization Management (UM) of hospital services shall have a plan health professional or a contracting physician available twenty-four (24) hours a day, seven (7) days a week to authorize Medically Necessary Post-Stabilization Services, to coordinate the transfer of stabilized Members in an emergency department if necessary, and for general communication with emergency room personnel.

B. Prior Authorization Request:

1. Prior Authorization request for Medically Necessary and Post-Stabilization Services shall be submitted in accordance with policy GG.1508: Authorization and Processing of Referrals.

2. Prior Authorization request for Medically Necessary post-stabilization services will be processed in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers.

3. Notification of UM Decision:

a. CalOptima Health and its Health Networks shall notify the requesting Practitioner or Provider and/or Member or Member's Authorized Representative, as appropriate, regarding any decision to deny, approve, modify, or delay an authorization request in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

b. For OneCare, CalOptima Health and its Health Networks shall ensure compliance with the notification requirements set forth in CalOptima Health Policy MA.6042: Integrated Organization Determinations.

C. For purposes of a Member transfer, it is the physician at the sending hospital that is primarily responsible for the determination of patient stability and clinical appropriateness for a transfer.

D. It is not considered an Interfacility Transfer when the following occur:

1. Movement of a stable patient from the originating Facility to another hospital for testing or outpatient procedure.

2. Member not been discharged from the originating Facility.

3. Will not remain overnight at receiving hospital.

4. Will return to the originating Facility after completion of testing or outpatient procedure.

E. Claims process for Interfacility Transfers:

1. Claims are processed in accordance with CalOptima Health Policy FF.1004: Payment for Hospitals Contracted to Serve a CalOptima Health Member, CalOptima Health Community Network Member, or a Member Enrolled in a Shared Risk Group.

2. If a Member is not discharged, sent to a second hospital for a procedure or testing, not discharged, and then returns to the originating hospital, the originating hospital is responsible for submitting claim, in accordance with CalOptima Health Policy FF.1004: Payment for Hospitals Contracted to Serve a CalOptima Health Member, CalOptima Health Community Network Member, or a Member Enrolled in a Shared Risk Group.

   a. The second hospital should not submit claim in accordance with CalOptima Health Policy FF.1004: Payment for Hospitals Contracted to Serve a CalOptima Health Member, CalOptima Health Community Network Member, or a Member Enrolled in a Shared Risk Group and DHCS Medi-Cal Diagnosis related groups FAQ FY 2022-23.

F. CalOptima Health will engage Members transferring from one setting or level of care to another ensuring Members are support from discharge planning until they have been successfully connected to all needed services and supports in accordance with CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services (TCS).

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy FF.1004: Payment for Hospitals Contracted to Serva a CalOptima Health Member, CalOptima Health Community Network Member, or a Member Enrolled in a Shared Risk Group
B. CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services (TCS)
C. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers
D. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
E. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
F. CalOptima Health Policy MA.6042: Integrated Organization Determinations
G. Centers for Medicare and Medicaid Services. Administration. Code of Federal Regulations. Chapter IV, Part 412.4; Prospective payment systems for inpatient hospital services. Discharges and transfers
H. Department of Health Care Services (DHCS) DRG/SFY/2022-23 Medi-Cal DRG FAQ
I. Department of Health Care Services (DHCS) Medi-Cal Billing Manual
J. Department of Health Care Services (DHCS): Administrative Days
K. 42 Code of Federal Regulations (CFR) CFR § 438.114
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-009: Post Stabilization Care Services.
M. 42 United States Code (USC) § 1395dd

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
TBD	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/05/2024	GG.1668	Inpatient Interfacility Transfers	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Acute Care Transfer	As defined by the Centers for Medicare & Medicaid Services (CMS), this occurs when a hospital patient is discharged and then readmitted to another hospital on the same day.
Authorized Representative	Medi-Cal: Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member. OneCare: Has the meaning given to the term Personal Representative in section 164.502(g) of Title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access by Member's Authorized Representative.
Facility	Any premise that is: 1. Owned, leased, used or operated directly or indirectly by or for CalOptima Health for purposes related in the DHCS Medi-Cal Contract, or 2. Maintained by a Provider to provide services on behalf of CalOptima Health.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Interfacility Transfer	Transfer of a member who is an admitted inpatient from one acute care facility to another acute care facility as an inpatient.
Medically Necessary or Medical Necessity	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 twenty-one (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 1396dI(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 twenty-one (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. OneCare: 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. PACE: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	A beneficiary enrolled in a CalOptima Health program.
Originating Facility	The acute care hospital where member is originally admitted as Inpatient and receiving services.
Plan of Care	An individual written plan of care completed, approved, and signed by a Physician and maintained in the Member's medical records according to Title 42, Code of Federal Regulations (CFR).
Post Stabilization Services	Covered services related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, to improve or resolved the condition.
Practitioner	A licensed independent practitioner including but not limited to a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist furnishing Covered Services.
Prior Authorization	Medi-Cal: A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services. OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a member to receive a specific service or procedure.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual

	that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Substance Use Disorder (SUD)	Those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.
Transfer Back	Transferring the member back to the originating hospital

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Financial Summary

October 31, 2024

Board of Directors Meeting
December 5, 2024

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

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

Financial Highlights: October 2024

October 2024 Actual	October 2024 Budget	October 2024 $ Variance	October 2024 % Variance		July - October 2024 Actual	July - October 2024 Budget	July - October 2024 $ Variance	July - October 2024 % Variance
910,063	898,380	11,683	1.3%	Member Months	3,650,442	3,604,985	45,457	1.3%
367,350,155	354,890,555	12,459,600	3.5%	Revenues	1,623,301,815	1,422,996,834	200,304,981	14.1%
349,543,471	364,859,583	15,316,112	4.2%	Medical Expenses	1,586,004,481	1,424,725,597	(161,278,884)	(11.3%)
22,721,241	24,615,739	1,894,498	7.7%	Administrative Expenses	79,207,551	96,381,292	17,173,741	17.8%
(4,914,556)	**(34,584,767)**	**29,670,211**	**85.8%**	**Operating Margin**	**(41,910,218)**	**(98,110,055)**	**56,199,837**	**57.3%**
				Non-Operating Income (Loss)				
1,958,461	6,666,660	(4,708,200)	(70.6%)	Net Investment Income/Expense	74,662,327	26,666,640	47,995,687	180.0%
(90,339)	(117,280)	26,941	23.0%	Net Rental Income/Expense	(182,538)	(469,120)	286,582	61.1%
(1,917)	-	(1,917)	(100.0%)	Net MCO Tax	4,836	-	4,836	100.0%
(14,260)	(1,178,825)	1,164,565	98.8%	Grant Expense	(2,510,119)	(4,624,391)	2,114,272	45.7%
10,891	-	10,891	100.0%	Other Income/Expense	66,603	-	66,603	100.0%
1,862,835	**5,370,555**	**(3,507,720)**	**(65.3%)**	**Total Non-Operating Income (Loss)**	**72,041,110**	**21,573,129**	**50,467,981**	**233.9%**
(3,051,720)	**(29,214,212)**	**26,162,492**	**89.6%**	**Change in Net Assets**	**30,130,892**	**(76,536,926)**	**106,667,818**	**139.4%**
95.2%	*102.8%*	*(7.7%)*		*Medical Loss Ratio*	*97.7%*	*100.1%*	*(2.4%)*	
6.2%	*6.9%*	*0.8%*		*Administrative Loss Ratio*	*4.9%*	*6.8%*	*1.9%*	
(1.3%)	*(9.7%)*	*8.4%*		*Operating Margin Ratio*	*(2.6%)*	*(6.9%)*	*4.3%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
90.0%	*97.9%*	*(7.9%)*		**Adjusted MLR*	*92.5%*	*95.2%*	*(2.7%)*	
6.2%	*6.9%*	*0.8%*		**Adjusted ALR*	*5.3%*	*6.8%*	*1.4%*	

*Adjusted MLR /ALR excludes estimated Board-approved Provider Rate increases, Directed Payments and Community Reinvestment Accruals

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Financial Highlights Notes: October 2024

- Notable events/items in October 2024
  - $31.2 million for Measurement Year (MY) 2023 Pay-for-Value paid to Health Networks for Medi-Cal (MC) Line of Business (LOB)

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FY 2024-25: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) October 2024: ($3.1) million, favorable to budget $26.2 million or 89.6% driven by MC LOB primarily due to:
    - Favorable premium capitation rates
    - Lower than expected utilization for the month
  - Year To Date (YTD) July - October 2024: $30.1 million, favorable to budget $106.7 million or 139.4% primarily due to:
    - Favorable net investment income and premium capitation rates and enrollment in the MC LOB
    - Offset by increased utilization

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FY 2024-25: Management Summary (cont.)

- Enrollment
  - MTD: 910,063 members, favorable to budget 11,683 or 1.3%
  - YTD: 3,650,442 member months, favorable to budget 45,457 or 1.3%

- Revenue
  - MTD: $367.4 million, favorable to budget $12.5 million or 3.5% driven by MC LOB primarily due to favorable premium capitation rates
  - YTD: $1,623.3 million, favorable to budget $200.3 million or 14.1% driven by MC LOB due to Calendar Year (CY) 2022 Directed Payments (DP) and enrollment

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FY 2024-25: Management Summary (cont.)

- Medical Expenses
  - MTD: $349.5 million, favorable to budget $15.3 million or 4.2% driven by MC LOB primarily due to lower than expected utilization in Professional Claims and Incentive Payments expenses
  - YTD: $1,586.0 million, unfavorable to budget $161.3 million or 11.3% driven by MC LOB primarily due to CY 2022 DP and Board-approved provider rate increases

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FY 2024-25: Management Summary (cont.)

- Administrative Expenses
  - MTD: $22.7 million, favorable to budget $1.9 million or 7.7%
  - YTD: $79.2 million, favorable to budget $17.2 million or 17.8%

- Non-Operating Income (Loss)
  - MTD: $1.9 million, unfavorable to budget $3.5 million or 65.3% primarily due to unfavorable net investment income driven by high interest rates causing a decrease in bond values
  - YTD: $72.0 million, favorable to budget $50.5 million or 233.9% primarily due to favorable net investment income

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FY 2024-25: Key Financial Ratios

- Medical Loss Ratio (MLR)

		Actual	Budget	Variance (%)
MTD	MLR	95.2%	102.8%	(7.7%)
	Adjusted MLR*	90.0%	97.9%	(7.9%)
YTD	MLR	97.7%	100.1%	(2.4%)
	Adjusted MLR*	92.5%	95.2%	(2.7%)

- Administrative Loss Ratio (ALR)

		Actual	Budget	Variance (%)
MTD	ALR	6.2%	6.9%	0.8%
	Adjusted ALR*	6.2%	6.9%	0.8%
YTD	ALR	4.9%	6.8%	1.9%
	Adjusted ALR*	5.3%	6.8%	1.4%

* Adjusted MLR/ALR excludes estimated Board-approved Provider Rate Increases, Directed Payments and Community Reinvestment Accruals

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FY 2024-25: Key Financial Ratios (cont.)

- Balance Sheet Ratios
  - Current ratio*: 1.8
  - Board Designated Reserve level: 2.72
  - Statutory Designated Reserve level: 1.02
  - Net-position: $2.5 billion, including required Tangible Net Equity (TNE) of $132.2 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations

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CalOptima Health

Enrollment Summary: October 2024

October 2024					July - October 2024			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
145,508	136,934	8,574	6.3%	SPD	578,875	545,504	33,371	6.1%
267,646	271,851	(4,205)	(1.5%)	TANF Child	1,080,156	1,090,954	(10,798)	(1.0%)
131,137	137,650	(6,513)	(4.7%)	TANF Adult	523,133	551,444	(28,311)	(5.1%)
2,501	2,604	(103)	(4.0%)	LTC	9,896	10,442	(546)	(5.2%)
336,051	321,857	14,194	4.4%	MCE	1,347,737	1,296,836	50,901	3.9%
9,549	9,546	3	0.0%	WCM	39,557	38,280	1,277	3.3%
892,392	**880,442**	**11,950**	**1.4%**	**Medi-Cal Total**	**3,579,354**	**3,533,460**	**45,894**	**1.3%**
17,173	**17,463**	**(290)**	**(1.7%)**	**OneCare**	**69,073**	**69,639**	**(566)**	**(0.8%)**
498	**475**	**23**	**4.8%**	**PACE**	**2,015**	**1,886**	**129**	**6.8%**
506	**568**	**(62)**	**(10.9%)**	**MSSP**	**1,946**	**2,272**	**(326)**	**(14.3%)**
910,063	**898,380**	**11,683**	**1.3%**	**CalOptima Health Total**	**3,650,442**	**3,604,985**	**45,457**	**1.3%**

*CalOptima Health Total does not include MSSP

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Consolidated Revenue & Expenses: October 2024 MTD

	Medi-Cal	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	892,392	17,173	498	506	910,063
REVENUES					
Capitation Revenue	$ 328,515,534	$ 34,315,388	$ 4,286,019	$ 233,214	$ 367,350,155
Total Operating Revenue	**328,515,534**	**34,315,388**	**4,286,019**	**233,214**	**367,350,155**
MEDICAL EXPENSES					
Provider Capitation	112,351,565	14,047,261			126,398,826
Claims	125,128,910	5,849,322	2,192,813		133,171,044
MLTSS	55,867,823		10,888	42,177	55,920,888
Prescription Drugs		11,159,285	550,907		11,710,191
Case Mgmt & Other Medical	19,349,171	1,538,956	1,255,841	198,553	22,342,521
Total Medical Expenses	**312,697,469**	**32,594,824**	**4,010,449**	**240,729**	**349,543,471**
Medical Loss Ratio	*95.2%*	*95.0%*	*93.6%*	*103.2%*	*95.2%*
GROSS MARGIN	**15,818,065**	**1,720,564**	**275,571**	**(7,515)**	**17,806,685**
ADMINISTRATIVE EXPENSES					
Salaries & Benefits	11,718,217	1,085,903	178,409	99,056	13,081,585
Non-Salary Operating Expenses	4,925,200	489,171	39,130	1,417	5,454,918
Depreciation & Amortization	800,657		971		801,628
Other Operating Expenses	2,923,022	26,836	11,064	8,174	2,969,096
Indirect Cost Allocation, Occupancy	(592,615)	983,956	16,321	6,353	414,014
Total Administrative Expenses	**19,774,480**	**2,585,866**	**245,894**	**115,000**	**22,721,241**
Administrative Loss Ratio	*6.0%*	*7.5%*	*5.7%*	*49.3%*	*6.2%*
Operating Income/(Loss)	**(3,956,415)**	**(865,302)**	**29,677**	**(122,515)**	**(4,914,556)**
Investments and Other Non-Operating	8,974				1,862,835
CHANGE IN NET ASSETS	**$ (3,947,441)**	**$ (865,302)**	**$ 29,677**	**$ (122,515)**	**$ (3,051,720)**
BUDGETED CHANGE IN NET ASSETS	(32,679,529)	(1,607,228)	(182,532)	(115,478)	(29,214,212)
Variance to Budget - Fav/(Unfav)	$ 28,732,088	$ 741,926	$ 212,209	$ (7,037)	$ 26,162,492

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Consolidated Revenue & Expenses: October 2024 YTD

	Medi-Cal	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	3,579,354	69,073	2,015	1,946	3,650,442
REVENUES					
Capitation Revenue	$ 1,469,886,856	$ 135,209,471	$ 17,320,895	$ 884,594	$ 1,623,301,815
Total Operating Revenue	**1,469,886,856**	**135,209,471**	**17,320,895**	**884,594**	**1,623,301,815**
MEDICAL EXPENSES					
Provider Capitation	448,814,598	58,627,748			507,442,345
Claims	561,012,388	22,855,115	6,319,415		590,186,918
MLTSS	205,356,666		30,533	141,834	205,529,033
Prescription Drugs		35,644,694	2,408,370		38,053,064
Case Mgmt & Other Medical	233,282,500	5,815,866	4,956,926	737,829	244,793,121
Total Medical Expenses	**1,448,466,152**	**122,943,422**	**13,715,244**	**879,663**	**1,586,004,481**
Medical Loss Ratio	*98.5%*	*90.9%*	*79.2%*	*99.4%*	*97.7%*
GROSS MARGIN	**21,420,704**	**12,266,048**	**3,605,651**	**4,931**	**37,297,334**
ADMINISTRATIVE EXPENSES					
Salaries & Benefits	44,875,265	4,362,894	647,734	371,532	50,257,425
Non-Salary Operating Expenses	12,754,200	1,586,907	198,161	5,680	14,544,949
Depreciation & Amortization	2,954,037		3,788		2,957,824
Other Operating Expenses	9,739,977	108,124	28,872	29,594	9,906,567
Indirect Cost Allocation, Occupancy	(2,485,732)	3,935,824	65,283	25,410	1,540,786
Total Administrative Expenses	**67,837,747**	**9,993,750**	**943,838**	**432,217**	**79,207,551**
Administrative Loss Ratio	*4.6%*	*7.4%*	*5.4%*	*48.9%*	*4.9%*
Operating Income/(Loss)	**(46,417,043)**	**2,272,299**	**2,661,813**	**(427,286)**	**(41,910,218)**
Investments and Other Non-Operating	71,439				72,041,110
CHANGE IN NET ASSETS	**$ (46,345,604)**	**$ 2,272,299**	**$ 2,661,813**	**$ (427,286)**	**$ 30,130,892**
BUDGETED CHANGE IN NET ASSETS	(92,470,049)	(4,656,547)	(529,564)	(453,895)	(76,536,926)
Variance to Budget - Fav/(Unfav)	$ 46,124,445	$ 6,928,846	$ 3,191,377	$ 26,609	$ 106,667,818

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Balance Sheet: As of October 2024

ASSETS	
Current Assets	
Operating Cash	$636,183,232
Short-term Investments	1,594,075,058
Receivables & Other Current Assets	707,277,462
Total Current Assets	**2,937,535,752**
Capital Assets	
Capital Assets	190,787,945
Less Accumulated Depreciation	(87,199,665)
Capital Assets, Net of Depreciation	103,588,281
Other Assets	
Restricted Deposits	300,000
Board Designated Reserves	1,030,468,550
Statutory Designated Reserves	135,091,898
Total Other Assets	**1,165,860,448**
TOTAL ASSETS	**4,206,984,481**
Deferred Outflows	**75,899,007**
TOTAL ASSETS & DEFERRED OUTFLOWS	**4,282,883,488**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$272,921,907
Medical Claims Liability	1,138,896,265
Capitation and Withholds	148,656,410
Other Current Liabilities	46,448,637
Total Current Liabilities	**1,606,923,220**
Other Liabilities	
GASB 96 Subscription Liabilities	21,387,713
Community Reinvestment	107,217,960
Postemployment Health Care Plan	17,513,725
Net Pension Liabilities	45,981,359
Total Other Liabilities	**192,100,757**
TOTAL LIABILITIES	**1,799,023,976**
Deferred Inflows	**8,646,445**
Net Position	
Required TNE	132,168,843
Funds in Excess of TNE	2,343,044,224
TOTAL NET POSITION	**2,475,213,067**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**4,282,883,488**

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Board Designated Reserve and TNE Analysis: As of October 2024

Board Designated Reserves

Investment Account Name	Market Value	Benchmark		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	515,362,884				
MetLife Tier One	515,105,666				
Board Designated Reserves	1,030,468,550	946,033,628	1,135,240,354	84,434,921	(104,771,804)
Current Reserve Level (X months of average monthly revenue) [1]	*2.72*	*2.50*	*3.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	Benchmark		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	67,678,927				
MetLife Tier Two	67,412,971				
Statutory Designated Reserves	135,091,899	132,168,843	145,385,727	2,923,056	(10,293,828)
Current Reserve Level (X min. TNE) [1]	*1.02*	*1.00*	*1.10*		

[1] *See CalOptima Health policy GA.3001 Statutory and Board-Designasted Reserve Funds for more information*

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Spending Plan: As of October 2024

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 10/31/2024	**$2,475.2**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,030.5**			**41.6%**
	Statutory Designated Reserve[1]	**$135.1**			**5.5%**
	Capital Assets, net of Depreciation[2]	**$103.6**			**4.2%**
Resources Allocated[3]	Homeless Health Initiative[3]	$16.8	$61.7	44.9	0.7%
	Housing and Homelessness Incentive Program[3]	22.2	87.4	65.1	0.9%
	Intergovernmental Transfers (IGT)	54.9	111.7	56.8	2.2%
	Digital Transformation and Workplace Modernization[4]	49.5	100.0	50.5	2.0%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	CalFresh Outreach Strategy	0.1	2.0	1.9	0.0%
	CalFresh and Redetermination Outreach Strategy	2.1	6.0	3.9	0.1%
	Coalition of Orange County Community Health Centers Grant	30.0	50.0	20.0	1.2%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	0.2	0.5	0.3	0.0%
	General Awareness Campaign	1.3	4.7	3.4	0.1%
	Member Health Needs Assessment	1.1	1.3	0.2	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	131.6	153.5	21.9	5.3%
	Medi-Cal Annual Wellness Initiative	2.5	3.8	1.3	0.1%
	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	3.5	5.0	1.5	0.1%
	Community Living and PACE center (previously approved for project located in Tustin)	17.6	18.0	0.4	0.7%
	Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program Grant	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	45.6	50.0	4.4	1.8%
	Distribution Event- Naloxone Grant	2.3	15.0	12.7	0.1%
	Garden Grove Bldg. Improvement	10.0	10.5	0.5	0.4%
	Post-Pandemic Supplemental	7.3	107.5	100.2	0.3%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.5%
	Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
	Outreach Strategy for newly eligible Adult Expansion members	5.6	7.6	2.0	0.2%
	Quality Initiatives from unearned Pay for Value Program	23.3	23.3	0.0	0.9%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.7	1.0	0.3	0.0%
	Medi-Cal Provider Rate Increases	456.0	526.2	70.2	18.4%
	Subtotal:	**$937.4**	**$1,422.3**	**$484.8**	**37.9%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$268.6**			**10.9%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 122 days of CalOptima Health's current operations
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements
[3] See HHI and HHIP summaries and Allocated Funds for list of Board approved initiatives. Amount reported includes only portion funded by reserves
[4] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024

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Homeless Health Initiative and Allocated Funds: As of October 2024

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	833,313	129,948
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,758,740	6,130,173
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine[1]	10,076,652	6,666,754	3,409,898
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[2]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$101,800,000**	**$44,917,760**	**$56,882,240**
Transfer of funds to HHIP[2]	(40,100,000)	-	(40,100,000)
Program Total	**$61,700,000**	**$44,917,760**	**$16,782,240**

Notes:

[1]On March 7, 2024, CalOptima Health's Board of Directors approved $5M. $3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and $1.8 million from existing reserves to fund 2-year agreements to Healthcare in Action and Celebrating Life Community Health Center

[2]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP

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Housing and Homelessness Incentive Program
As of October 2024

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	35,200,994	28,876,725	6,324,269	37,730,195[1]
Existing Reserves & HHI Transfer	87,384,530	87,384,530	65,134,997	22,249,533	-
Total	**160,315,719**	**122,585,524**	**94,011,722**	**28,573,802**	**37,730,195**

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	800,000	692,350	107,650	HHI
Consultant	600,000	-	600,000	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	3,271,805	749,507	HHI & DHCS
Infrastructure Projects	5,832,314	5,391,731	440,583	HHI
Capital Projects	98,247,369	77,195,575	21,051,794	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	4,863,856	5,320,674	DHCS
Non-Profit Healthcare Academy	700,000	396,404	303,596	DHCS
Total of Approved Initiatives	**$122,585,524[1]**	**$94,011,721**	**$28,573,803**	

Notes:

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments

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UNAUDITED FINANCIAL STATEMENTS

October 31, 2024

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CalOptima Health - Consolidated
Financial Highlights
For the Four Months Ending October 31, 2024

October 2024					July - October 2024			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
910,063	898,380	11,683	1.3%	Member Months	3,650,442	3,604,985	45,457	1.3%
367,350,155	354,890,555	12,459,600	3.5%	Revenues	1,623,301,815	1,422,996,834	200,304,981	14.1%
349,543,471	364,859,583	15,316,112	4.2%	Medical Expenses	1,586,004,481	1,424,725,597	(161,278,884)	(11.3%)
22,721,241	24,615,739	1,894,498	7.7%	Administrative Expenses	79,207,551	96,381,292	17,173,741	17.8%
(4,914,556)	**(34,584,767)**	**29,670,211**	**85.8%**	**Operating Margin**	**(41,910,218)**	**(98,110,055)**	**56,199,837**	**57.3%**
				Non-Operating Income (Loss)				
1,958,461	6,666,660	(4,708,200)	(70.6%)	Net Investment Income/Expense	74,662,327	26,666,640	47,995,687	180.0%
(90,339)	(117,280)	26,941	23.0%	Net Rental Income/Expense	(182,538)	(469,120)	286,582	61.1%
(1,917)	-	(1,917)	(100.0%)	Net MCO Tax	4,836	-	4,836	100.0%
(14,260)	(1,178,825)	1,164,565	98.8%	Grant Expense	(2,510,119)	(4,624,391)	2,114,272	45.7%
10,891	-	10,891	100.0%	Other Income/Expense	66,603	-	66,603	100.0%
1,862,835	**5,370,555**	**(3,507,720)**	**(65.3%)**	**Total Non-Operating Income (Loss)**	**72,041,110**	**21,573,129**	**50,467,981**	**233.9%**
(3,051,720)	**(29,214,212)**	**26,162,492**	**89.6%**	**Change in Net Assets**	**30,130,892**	**(76,536,926)**	**106,667,818**	**139.4%**
95.2%	*102.8%*	*(7.7%)*		*Medical Loss Ratio*	*97.7%*	*100.1%*	*(2.4%)*	
6.2%	*6.9%*	*0.8%*		*Administrative Loss Ratio*	*4.9%*	*6.8%*	*1.9%*	
(1.3%)	*(9.7%)*	*8.4%*		*Operating Margin Ratio*	*(2.6%)*	*(6.9%)*	*4.3%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
90.0%	*97.9%*	*(7.9%)*		**Adjusted MLR*	*92.5%*	*95.2%*	*(2.7%)*	
6.2%	*6.9%*	*0.8%*		**Adjusted ALR*	*5.3%*	*6.8%*	*1.4%*	

*Adjusted MLR /ALR excludes estimated Board-approved Provider Rate increases, Directed Payments and Community Reinvestment Accruals

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CalOptima Health - Consolidated
Full Time Employee Data
For the Four Months Ending October 31, 2024

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1,292	1,361	69
OneCare	170	186	16
PACE	106	113	7
MSSP	22	25	3
Total	1,589	1,685	96

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	5,141	5,443	302
OneCare	689	744	55
PACE	425	452	27
MSSP	82	100	18
Total	6,337	6,739	402

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	691	647	(44)
OneCare	101	94	(7)
PACE	5	4	(1)
MSSP	23	23	0
Consolidated	573	533	(40)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	696	649	(47)
OneCare	100	94	(6)
PACE	5	4	(1)
MSSP	24	23	(1)
Consolidated	576	535	(41)

Open FTE			
	Total	Medical	Admin
Medi-Cal	68	21	47
OneCare	11	8	3
PACE	8	7	1
MSSP	1	1	0
Total	88	37	51

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending October 31, 2024

MEMBER MONTHS		910,063		898,380		11,683
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$328,515,534	$368.13	$315,836,336	$358.72	$12,679,198	$9.41
OneCare	34,315,388	1,998.22	34,863,353	1,996.41	(547,965)	1.81
OneCare Connect	-		-		-	-
PACE	4,286,019	8,606.46	3,937,349	8,289.16	348,670	317.30
MSSP	233,214	460.90	253,517	446.33	(20,303)	14.57
Total Operating Revenue	367,350,155	403.65	354,890,555	395.03	12,459,600	8.62
MEDICAL EXPENSES						
Medi-Cal	312,697,469	350.40	327,591,156	372.08	14,893,687	21.68
OneCare	32,594,824	1,898.03	33,208,898	1,901.67	614,074	3.64
PACE	4,010,449	8,053.11	3,818,788	8,039.55	(191,661)	(13.56)
MSSP	240,729	475.75	240,741	423.84	12	(51.91)
Total Medical Expenses	349,543,471	384.09	364,859,583	406.13	15,316,112	22.04
GROSS MARGIN	17,806,685	19.56	(9,969,028)	(11.10)	27,775,713	30.66
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	13,081,585	14.37	13,831,106	15.40	749,521	1.03
Professional Fees	2,202,341	2.42	1,562,470	1.74	(639,870)	(0.68)
Purchased Services	2,825,596	3.10	3,098,063	3.45	272,467	0.35
Printing & Postage	426,981	0.47	794,038	0.88	367,057	0.41
Depreciation & Amortization	801,628	0.88	1,027,958	1.14	226,330	0.26
Other Expenses	2,969,096	3.26	3,858,501	4.29	889,404	1.03
Indirect Cost Allocation, Occupancy	414,014	0.45	443,603	0.49	29,589	0.04
Total Administrative Expenses	22,721,241	24.97	24,615,739	27.40	1,894,498	2.43
NET INCOME (LOSS) FROM OPERATIONS	(4,914,556)	(5.40)	(34,584,767)	(38.50)	29,670,211	33.10
INVESTMENT INCOME						
Interest Income	14,870,974	16.34	6,666,660	7.42	8,204,314	8.92
Realized Gain/(Loss) on Investments	1,411,993	1.55	-	-	1,411,993	1.55
Unrealized Gain/(Loss) on Investments	(14,324,506)	(15.74)	-	-	(14,324,506)	(15.74)
Total Investment Income	1,958,461	2.15	6,666,660	7.42	(4,708,200)	(5.27)
NET RENTAL INCOME/EXPENSE	(90,339)	(0.10)	(117,280)	(0.13)	26,941	0.03
NET MCO TAX	(1,917)	-	-	-	(1,917)	-
GRANT EXPENSE	(14,260)	(0.02)	(1,178,825)	(1.31)	1,164,565	1.29
OTHER INCOME/EXPENSE	10,891	0.01	-	-	10,891	0.01
CHANGE IN NET ASSETS	**(3,051,720)**	**(3.35)**	**(29,214,212)**	**(32.52)**	**26,162,492**	**29.17**
MEDICAL LOSS RATIO	**95.2%**		**102.8%**		**(7.7%)**	
ADMINISTRATIVE LOSS RATIO	**6.2%**		**6.9%**		**0.8%**	

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CalOptima Health- Consolidated - Year to Date
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2024

MEMBER MONTHS		3,650,442		3,604,985		45,457
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$1,469,886,856	$410.66	$1,266,294,959	$358.37	$203,591,897	$52.29
OneCare	135,209,471	1,957.49	140,025,108	2,010.73	(4,815,637)	(53.24)
OneCare Connect	-		-		-	0.00
PACE	17,320,895	8,595.98	15,662,699	8,304.72	1,658,196	291.26
MSSP	884,594	454.57	1,014,068	446.33	(129,474)	8.24
Total Operating Revenue	1,623,301,815	444.69	1,422,996,834	394.73	200,304,981	49.96
MEDICAL EXPENSES						
Medi-Cal	1,448,466,152	404.67	1,276,804,529	361.35	(171,661,623)	(43.32)
OneCare	122,943,422	1,779.91	131,955,779	1,894.85	9,012,357	114.94
PACE	13,715,244	6,806.57	15,002,325	7,954.57	1,287,081	1,148.00
MSSP	879,663	452.04	962,964	423.84	83,301	(28.20)
Total Medical Expenses	1,586,004,481	434.47	1,424,725,597	395.21	(161,278,884)	(39.26)
GROSS MARGIN	37,297,334	10.22	(1,728,763)	(0.48)	39,026,097	10.70
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	50,257,425	13.77	54,242,525	15.05	3,985,100	1.28
Professional Fees	4,870,279	1.33	6,102,048	1.69	1,231,769	0.36
Purchased Services	7,951,915	2.18	11,334,607	3.14	3,382,692	0.96
Printing & Postage	1,722,755	0.47	3,275,667	0.91	1,552,912	0.44
Depreciation & Amortization	2,957,824	0.81	4,111,832	1.14	1,154,008	0.33
Other Expenses	9,906,567	2.71	15,540,521	4.31	5,633,954	1.60
Indirect Cost Allocation, Occupancy	1,540,786	0.42	1,774,092	0.49	233,306	0.07
Total Administrative Expenses	79,207,551	21.70	96,381,292	26.74	17,173,741	5.04
NET INCOME (LOSS) FROM OPERATIONS	(41,910,218)	(11.48)	(98,110,055)	(27.22)	56,199,837	15.74
INVESTMENT INCOME						
Interest Income	60,793,989	16.65	26,666,640	7.40	34,127,349	9.25
Realized Gain/(Loss) on Investments	1,816,327	0.50	-	0.00	1,816,327	0.50
Unrealized Gain/(Loss) on Investments	12,052,012	3.30	-	0.00	12,052,012	3.30
Total Investment Income	74,662,327	20.45	26,666,640	7.40	47,995,687	13.05
NET RENTAL INCOME/EXPENSE	(182,538)	(0.05)	(469,120)	(0.13)	286,582	0.08
NET MCO TAX	4,836	0.00	-	0.00	4,836	0.00
GRANT EXPENSE	(2,510,119)	(0.69)	(4,624,391)	(1.28)	2,114,272	0.59
OTHER INCOME/EXPENSE	66,603	0.02	-	0.00	66,603	0.02
CHANGE IN NET ASSETS	**30,130,892**	**8.25**	**(76,536,926)**	**(21.23)**	**106,667,818**	**29.48**
MEDICAL LOSS RATIO	**97.7%**		**100.1%**		**(2.4%)**	
ADMINISTRATIVE LOSS RATIO	**4.9%**		**6.8%**		**1.9%**	

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CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending October 31, 2024

	Medi-Cal	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	892,392	17,173	498	506	910,063
REVENUES					
Capitation Revenue	$ 328,515,534	$ 34,315,388	$ 4,286,019	$ 233,214	$ 367,350,155
Total Operating Revenue	**328,515,534**	**34,315,388**	**4,286,019**	**233,214**	**367,350,155**
MEDICAL EXPENSES					
Provider Capitation	112,351,565	14,047,261			126,398,826
Claims	125,128,910	5,849,322	2,192,813		133,171,044
MLTSS	55,867,823		10,888	42,177	55,920,888
Prescription Drugs		11,159,285	550,907		11,710,191
Case Mgmt & Other Medical	19,349,171	1,538,956	1,255,841	198,553	22,342,521
Total Medical Expenses	**312,697,469**	**32,594,824**	**4,010,449**	**240,729**	**349,543,471**
Medical Loss Ratio	*95.2%*	*95.0%*	*93.6%*	*103.2%*	*95.2%*
GROSS MARGIN	**15,818,065**	**1,720,564**	**275,571**	**(7,515)**	**17,806,685**
ADMINISTRATIVE EXPENSES					
Salaries & Benefits	11,718,217	1,085,903	178,409	99,056	13,081,585
Non-Salary Operating Expenses	4,925,200	489,171	39,130	1,417	5,454,918
Depreciation & Amortization	800,657		971		801,628
Other Operating Expenses	2,923,022	26,836	11,064	8,174	2,969,096
Indirect Cost Allocation, Occupancy	(592,615)	983,956	16,321	6,353	414,014
Total Administrative Expenses	**19,774,480**	**2,585,866**	**245,894**	**115,000**	**22,721,241**
Administrative Loss Ratio	*6.0%*	*7.5%*	*5.7%*	*49.3%*	*6.2%*
Operating Income/(Loss)	**(3,956,415)**	**(865,302)**	**29,677**	**(122,515)**	**(4,914,556)**
Investments and Other Non-Operating	8,974				1,862,835
CHANGE IN NET ASSETS	**$ (3,947,441)**	**$ (865,302)**	**$ 29,677**	**$ (122,515)**	**$ (3,051,720)**
BUDGETED CHANGE IN NET ASSETS	(32,679,529)	(1,607,228)	(182,532)	(115,478)	(29,214,212)
Variance to Budget - Fav/(Unfav)	$ 28,732,088	$ 741,926	$ 212,209	$ (7,037)	$ 26,162,492

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CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Four Months Ending October 31, 2024

	Medi-Cal	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	3,579,354	69,073	2,015	1,946	3,650,442
REVENUES					
Capitation Revenue	$ 1,469,886,856	$ 135,209,471	$ 17,320,895	$ 884,594	$ 1,623,301,815
Total Operating Revenue	**1,469,886,856**	**135,209,471**	**17,320,895**	**884,594**	**1,623,301,815**
MEDICAL EXPENSES					
Provider Capitation	448,814,598	58,627,748			507,442,345
Claims	561,012,388	22,855,115	6,319,415		590,186,918
MLTSS	205,356,666		30,533	141,834	205,529,033
Prescription Drugs		35,644,694	2,408,370		38,053,064
Case Mgmt & Other Medical	233,282,500	5,815,866	4,956,926	737,829	244,793,121
Total Medical Expenses	**1,448,466,152**	**122,943,422**	**13,715,244**	**879,663**	**1,586,004,481**
Medical Loss Ratio	*98.5%*	*90.9%*	*79.2%*	*99.4%*	*97.7%*
GROSS MARGIN	**21,420,704**	**12,266,048**	**3,605,651**	**4,931**	**37,297,334**
ADMINISTRATIVE EXPENSES					
Salaries & Benefits	44,875,265	4,362,894	647,734	371,532	50,257,425
Non-Salary Operating Expenses	12,754,200	1,586,907	198,161	5,680	14,544,949
Depreciation & Amortization	2,954,037		3,788		2,957,824
Other Operating Expenses	9,739,977	108,124	28,872	29,594	9,906,567
Indirect Cost Allocation, Occupancy	(2,485,732)	3,935,824	65,283	25,410	1,540,786
Total Administrative Expenses	**67,837,747**	**9,993,750**	**943,838**	**432,217**	**79,207,551**
Administrative Loss Ratio	*4.6%*	*7.4%*	*5.4%*	*48.9%*	*4.9%*
Operating Income/(Loss)	**(46,417,043)**	**2,272,299**	**2,661,813**	**(427,286)**	**(41,910,218)**
Investments and Other Non-Operating	71,439				72,041,110
CHANGE IN NET ASSETS	**$ (46,345,604)**	**$ 2,272,299**	**$ 2,661,813**	**$ (427,286)**	**$ 30,130,892**
BUDGETED CHANGE IN NET ASSETS	(92,470,049)	(4,656,547)	(529,564)	(453,895)	(76,536,926)
Variance to Budget - Fav/(Unfav)	$ 46,124,445	$ 6,928,846	$ 3,191,377	$ 26,609	$ 106,667,818

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CalOptima Health

Unaudited Financial Statements as of October 31, 2024

MONTHLY RESULTS:

- Change in Net Assets is ($3.1) million, favorable to budget $26.2 million
- Operating deficit is $4.9 million, with a surplus in non-operating income of $1.9 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $30.1 million, favorable to budget $106.7 million
- Operating deficit is $41.9 million, with a surplus in non-operating income of $72.0 million

Change in Net Assets by Line of Business (LOB) ($ millions):

October 2024				July - October 2024		
Actual	**Budget**	**Variance**	**Operating Income (Loss)**	**Actual**	**Budget**	**Variance**
(4.0)	(32.7)	28.7	Medi-Cal	(46.4)	(92.5)	46.1
(0.9)	(1.6)	0.7	OneCare	2.3	(4.7)	6.9
0.0	(0.2)	0.2	PACE	2.7	(0.5)	3.2
(0.1)	(0.1)	0.0	MSSP	(0.4)	(0.5)	0.0
(4.9)	**(34.6)**	**29.7**	**Total Operating Income (Loss)**	**(41.9)**	**(98.1)**	**56.2**
			Non-Operating Income (Loss)			
2.0	6.7	(4.7)	Net Investment Income/Expense	74.7	26.7	48.0
(0.1)	(0.1)	0.0	Net Rental Income/Expense	(0.2)	(0.5)	0.3
0.0	(1.2)	1.2	Grant Expense	(2.5)	(4.6)	2.1
0.0	0.0	0.0	Other Income/Expense	0.1	0.0	0.1
1.9	**5.4**	**(3.5)**	**Total Non-Operating Income/(Loss)**	**72.0**	**21.6**	**50.5**
(3.1)	**(29.2)**	**26.2**	**TOTAL**	**30.1**	**(76.5)**	**106.7**

CalOptima Health - Consolidated
Enrollment Summary
For the Four Months Ending October 31, 2024

October 2024					July - October 2024			
Actual	**Budget**	**$ Variance**	**%Variance**	**Enrollment (by Aid Category)**	**Actual**	**Budget**	**$ Variance**	**%Variance**
145,508	136,934	8,574	6.3%	SPD	578,875	545,504	33,371	6.1%
267,646	271,851	(4,205)	(1.5%)	TANF Child	1,080,156	1,090,954	(10,798)	(1.0%)
131,137	137,650	(6,513)	(4.7%)	TANF Adult	523,133	551,444	(28,311)	(5.1%)
2,501	2,604	(103)	(4.0%)	LTC	9,896	10,442	(546)	(5.2%)
336,051	321,857	14,194	4.4%	MCE	1,347,737	1,296,836	50,901	3.9%
9,549	9,546	3	0.0%	WCM	39,557	38,280	1,277	3.3%
892,392	**880,442**	**11,950**	**1.4%**	**Medi-Cal Total**	**3,579,354**	**3,533,460**	**45,894**	**1.3%**
17,173	**17,463**	**(290)**	**(1.7%)**	**OneCare**	**69,073**	**69,639**	**(566)**	**(0.8%)**
498	**475**	**23**	**4.8%**	**PACE**	**2,015**	**1,886**	**129**	**6.8%**
506	**568**	**(62)**	**(10.9%)**	**MSSP**	**1,946**	**2,272**	**(326)**	**(14.3%)**
910,063	**898,380**	**11,683**	**1.3%**	**CalOptima Health Total**	**3,650,442**	**3,604,985**	**45,457**	**1.3%**
				Enrollment (by Network)				
288,128	302,541	(14,413)	(4.8%)	HMO	1,164,303	1,214,429	(50,126)	(4.1%)
174,824	178,428	(3,604)	(2.0%)	PHC	707,368	716,411	(9,043)	(1.3%)
142,890	132,394	10,496	7.9%	Shared Risk Group	574,152	534,749	39,403	7.4%
286,550	267,079	19,471	7.3%	Fee for Service	1,133,531	1,067,871	65,660	6.1%
892,392	**880,442**	**11,950**	**1.4%**	**Medi-Cal Total**	**3,579,354**	**3,533,460**	**45,894**	**1.3%**
17,173	**17,463**	**(290)**	**(0)**	**OneCare**	**69,073**	**69,639**	**(566)**	**(0)**
498	**475**	**23**	**4.8%**	**PACE**	**2,015**	**1,886**	**129**	**6.8%**
506	**568**	**(62)**	**(10.9%)**	**MSSP**	**1,946**	**2,272**	**(326)**	**(14.3%)**
910,063	**898,380**	**11,683**	**1.3%**	**CalOptima Health Total**	**3,650,442**	**3,604,985**	**45,457**	**1.3%**

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2025

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD Actual	YTD Budget	Variance
HMOs															
SPD	17,150	16,511	16,610	16,774									67,045	65,414	1,631
TANF Child	66,405	65,921	65,198	64,503									262,027	275,826	(13,799)
TANF Adult	54,590	55,734	55,056	54,535									219,915	251,745	(31,830)
LTC	2												2		2
MCE	153,578	153,602	152,129	151,153									610,462	615,928	(5,466)
WCM	1,241	1,234	1,214	1,163									4,852	5,516	(664)
Total	292,966	293,002	290,207	288,128									1,164,303	1,214,429	**(50,126)**
PHCs															
SPD	4,906	4,644	4,820	4,796									19,166	18,049	1,117
TANF Child	140,053	138,903	137,874	136,823									553,653	566,396	(12,743)
TANF Adult	3,994	4,186	4,191	4,104									16,475	19,684	(3,209)
LTC													0		0
MCE	22,999	22,762	22,600	22,551									90,912	86,492	4,420
WCM	6,571	7,308	6,733	6,550									27,162	25,790	1,372
Total	178,523	177,803	176,218	174,824									707,368	716,411	**(9,043)**
Shared Risk Groups															
SPD	7,270	7,077	7,057	7,133									28,537	25,951	2,586
TANF Child	32,783	32,842	32,545	32,325									130,495	126,246	4,249
TANF Adult	27,519	29,041	28,870	28,586									114,016	116,117	(2,101)
LTC				1									1	4	(3)
MCE	74,704	74,918	74,517	74,138									298,277	263,495	34,782
WCM	702	701	716	707									2,826	2,936	(110)
Total	**142,978**	**144,579**	**143,705**	**142,890**									**574,152**	**534,749**	**39,403**
Fee for Service (Dual)															
SPD	100,293	99,792	100,297	100,986									401,368	377,176	24,192
TANF Child													0	6	(6)
TANF Adult	1,145	1,159	1,123	1,052									4,479	7,262	(2,783)
LTC	2,178	2,203	2,209	2,222									8,812	9,343	(531)
MCE	4,008	4,703	4,593	4,431									17,735	36,076	(18,341)
WCM	6	7	8	15									36	36	0
Total	**107,630**	**107,864**	**108,230**	**108,706**									**432,430**	**429,899**	**2,531**
Fee for Service (Non-Dual - Total)															
SPD	15,636	15,436	15,868	15,819									62,759	58,914	3,845
TANF Child	32,741	33,377	33,868	33,995									133,981	122,480	11,501
TANF Adult	40,618	42,145	42,625	42,860									168,248	156,636	11,612
LTC	278	254	271	278									1,081	1,095	(14)
MCE	80,536	82,491	83,546	83,778									330,351	294,845	35,506
WCM	1,205	1,184	1,178	1,114									4,681	4,002	679
Total	**171,014**	**174,887**	**177,356**	**177,844**									**701,101**	**637,972**	**63,129**
Grand Totals															
SPD	145,255	143,460	144,652	145,508									578,875	545,504	33,371
TANF Child	271,982	271,043	269,485	267,646									1,080,156	1,090,954	(10,798)
TANF Adult	127,866	132,265	131,865	131,137									523,133	551,444	(28,311)
LTC	2,458	2,457	2,480	2,501									9,896	10,442	(546)
MCE	335,825	338,476	337,385	336,051									1,347,737	1,296,836	50,901
WCM	9,725	10,434	9,849	9,549									39,557	38,280	1,277
Total MediCal MM	**893,111**	**898,135**	**895,716**	**892,392**									**3,579,354**	**3,533,460**	**45,894**
OneCare	**17,311**	**17,307**	**17,282**	**17,173**									**69,073**	**69,639**	**(566)**
PACE	**506**	**508**	**503**	**498**									**2,015**	**1,886**	**129**
MSSP	**473**	**480**	**487**	**506**									**1,946**	**2,272**	**(326)**
Grand Total	**910,928**	**915,950**	**913,501**	**910,063**									**3,650,442**	**3,604,985**	**45,457**

Note:* Total membership does not include MSSP

ENROLLMENT:

Overall, October enrollment was 910,063

- Favorable to budget 11,683 or 1.3%
- Decreased 3,438 or 0.4% from Prior Month (PM) (September 2024)
- Decreased 59,668 or 6.2% from Prior Year (PY) (October 2023)

Medi-Cal enrollment was 892,392

- Favorable to budget 11,950 or 1.4%
- Medi-Cal Expansion (MCE) favorable to budget 14,194
- Seniors and Persons with Disabilities (SPD) favorable to budget 8,574
- Whole Child Model (WCM) favorable to budget 3
- Temporary Assistance for Needy Families (TANF) unfavorable to budget 10,718
- Long-Term Care (LTC) unfavorable to budget 103
- Decreased 3,324 from PM

OneCare enrollment was 17,173

- Unfavorable to budget 290 or 1.7%
- Decreased 109 from PM

PACE enrollment was 498

- Favorable to budget 23 or 4.8%
- Decreased 5 from PM

MSSP enrollment was 506

- Unfavorable to budget 62 or 10.9%
- Increased 19 from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2024

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
892,392	**880,442**	**11,950**	**1.4%**	**Member Months**	**3,579,354**	**3,533,460**	**45,894**	**1.3%**
				Revenues				
328,515,534	315,836,336	12,679,198	4.0%	Medi-Cal Capitation Revenue	1,469,886,856	1,266,294,959	203,591,897	16.1%
328,515,534	**315,836,336**	**12,679,198**	**4.0%**	**Total Operating Revenue**	**1,469,886,856**	**1,266,294,959**	**203,591,897**	**16.1%**
				Medical Expenses				
112,351,565	111,304,326	(1,047,239)	(0.9%)	Provider Capitation	448,814,598	447,061,359	(1,753,239)	(0.4%)
71,731,063	65,820,737	(5,910,326)	(9.0%)	Facilities Claims	288,051,165	260,702,603	(27,348,562)	(10.5%)
53,397,847	69,827,112	16,429,265	23.5%	Professional Claims	272,961,223	279,621,394	6,660,171	2.4%
55,867,823	49,366,279	(6,501,544)	(13.2%)	MLTSS	205,356,666	195,003,207	(10,353,459)	(5.3%)
8,047,533	20,136,779	12,089,246	60.0%	Incentive Payments	46,844,918	50,747,928	3,903,010	7.7%
8,204,241	9,305,714	1,101,473	11.8%	Medical Management	32,326,800	36,347,202	4,020,402	11.1%
3,097,397	1,830,209	(1,267,188)	(69.2%)	Other Medical Expenses	154,110,783	7,320,836	(146,789,947)	(2,005.1%)
312,697,469	**327,591,156**	**14,893,687**	**4.5%**	**Total Medical Expenses**	**1,448,466,152**	**1,276,804,529**	**(171,661,623)**	**(13.4%)**
15,818,065	**(11,754,820)**	**27,572,885**	**234.6%**	**Gross Margin**	**21,420,704**	**(10,509,570)**	**31,930,274**	**303.8%**
				Administrative Expenses				
11,718,217	12,308,238	590,021	4.8%	Salaries, Wages & Employee Benefits	44,875,265	48,261,060	3,385,795	7.0%
2,172,319	1,430,862	(741,457)	(51.8%)	Professional Fees	4,517,988	5,614,116	1,096,128	19.5%
2,476,481	2,524,070	47,589	1.9%	Purchased Services	6,965,482	9,232,815	2,267,333	24.6%
276,400	525,563	249,163	47.4%	Printing & Postage	1,270,729	2,201,767	931,038	42.3%
800,657	1,026,358	225,701	22.0%	Depreciation & Amortization	2,954,037	4,105,432	1,151,395	28.0%
2,923,022	3,716,049	793,027	21.3%	Other Operating Expenses	9,739,977	14,971,013	5,231,036	34.9%
(592,615)	(606,431)	(13,816)	(2.3%)	Indirect Cost Allocation, Occupancy	(2,485,732)	(2,425,724)	60,008	2.5%
19,774,480	**20,924,709**	**1,150,229**	**5.5%**	**Total Administrative Expenses**	**67,837,747**	**81,960,479**	**14,122,732**	**17.2%**
				Non-Operating Income (Loss)				
(1,917)	-	(1,917)	(100.0%)	Net Operating Tax	4,836	-	4,836	100.0%
10,891	-	10,891	100.0%	Other Income/Expense	66,603	-	66,603	100.0%
8,974	**-**	**8,974**	**100.0%**	**Total Non-Operating Income (Loss)**	**71,439**	**-**	**71,439**	**100.0%**
(3,947,441)	**(32,679,529)**	**28,732,088**	**87.9%**	**Change in Net Assets**	**(46,345,604)**	**(92,470,049)**	**46,124,445**	**49.9%**
95.2%	***103.7%***	***(8.5%)***		***Medical Loss Ratio***	***98.5%***	***100.8%***	***(2.3%)***	
6.0%	***6.6%***	***0.6%***		***Admin Loss Ratio***	***4.6%***	***6.5%***	***1.9%***	

MEDI-CAL INCOME STATEMENT– OCTOBER MONTH:

REVENUES of $328.5 million are favorable to budget $12.7 million driven by:

- Favorable volume related variance of $4.3 million
- Favorable price related variance of $8.4 million primarily due to favorable premium capitation rates

MEDICAL EXPENSES of $312.7 million are favorable to budget $14.9 million driven by:

- Unfavorable volume related variance of $4.4 million
- Favorable price related variance of $19.3 million due to:
  - Professional Claims expenses favorable variance of $17.4 million due to lower than expected utilization
  - Incentive Payments expenses favorable variance of $12.4 million due to Hospital Quality Program
  - Medical Management expense favorable variance of $1.2 million
  - Provider Capitation expenses favorable variance of $0.5 million
  - Offset by:
    - Managed Long-Term Services and Supports (MLTSS) expenses unfavorable variance of $5.8 million
    - Facilities Claims expenses unfavorable variance of $5.0 million
    - Other Medical Expenses unfavorable variance of $1.2 million

ADMINISTRATIVE EXPENSES of $19.8 million are favorable to budget $1.2 million driven by:

- Salaries, Wages & Employee Benefits expense favorable to budget $0.6 million
- Non-Salary expenses favorable to budget $0.6 million

CHANGE IN NET ASSETS is ($3.9) million, favorable to budget $28.7 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
17,173	**17,463**	**(290)**	**(1.7%)**	**Member Months**	**69,073**	**69,639**	**(566)**	**(0.8%)**
				Revenues				
23,632,233	25,459,939	(1,827,706)	(7.2%)	Medicare Part C Revenue	97,165,716	102,496,181	(5,330,465)	(5.2%)
10,683,155	9,403,414	1,279,741	13.6%	Medicare Part D Revenue	38,043,754	37,528,927	514,827	1.4%
34,315,388	**34,863,353**	**(547,965)**	**(1.6%)**	**Total Operating Revenue**	**135,209,471**	**140,025,108**	**(4,815,637)**	**(3.4%)**
				Medical Expenses				
14,047,261	15,550,884	1,503,623	9.7%	Provider Capitation	58,627,748	62,596,606	3,968,858	6.3%
3,889,361	4,965,508	1,076,147	21.7%	Inpatient	15,617,361	19,229,231	3,611,870	18.8%
1,959,961	1,762,036	(197,925)	(11.2%)	Ancillary	7,237,754	6,951,655	(286,099)	(4.1%)
11,159,285	9,082,141	(2,077,144)	(22.9%)	Prescription Drugs	35,644,694	35,678,416	33,722	0.1%
527,298	447,098	(80,200)	(17.9%)	Incentive Payments	1,790,187	1,986,071	195,884	9.9%
1,011,658	1,401,231	389,573	27.8%	Medical Management	4,025,680	5,513,800	1,488,120	27.0%
32,594,824	**33,208,898**	**614,074**	**1.8%**	**Total Medical Expenses**	**122,943,422**	**131,955,779**	**9,012,357**	**6.8%**
1,720,564	**1,654,455**	**66,109**	**4.0%**	**Gross Margin**	**12,266,048**	**8,069,329**	**4,196,719**	**52.0%**
				Administrative Expenses				
1,085,903	1,234,703	148,800	12.1%	Salaries, Wages & Employee Benefits	4,362,894	4,850,936	488,042	10.1%
27,053	121,483	94,431	77.7%	Professional Fees	340,488	447,132	106,644	23.9%
311,538	513,960	202,422	39.4%	Purchased Services	796,644	1,861,660	1,065,016	57.2%
150,581	243,950	93,369	38.3%	Printing & Postage	449,775	975,800	526,025	53.9%
26,836	121,504	94,668	77.9%	Other Operating Expenses	108,124	486,016	377,892	77.8%
983,956	1,026,083	42,127	4.1%	Indirect Cost Allocation, Occupancy	3,935,824	4,104,332	168,508	4.1%
2,585,866	**3,261,683**	**675,817**	**20.7%**	**Total Administrative Expenses**	**9,993,750**	**12,725,876**	**2,732,126**	**21.5%**
(865,302)	**(1,607,228)**	**741,926**	**46.2%**	**Change in Net Assets**	**2,272,299**	**(4,656,547)**	**6,928,846**	**148.8%**
95.0%	***95.3%***	***(0.3%)***		***Medical Loss Ratio***	***90.9%***	***94.2%***	***(3.3%)***	
7.5%	***9.4%***	***1.8%***		***Admin Loss Ratio***	***7.4%***	***9.1%***	***1.7%***	

ONECARE INCOME STATEMENT– OCTOBER MONTH:

REVENUES of $34.3 million are unfavorable to budget $0.5 million driven by:

- Unfavorable volume related variance of $0.6 million

MEDICAL EXPENSES of $32.6 million are favorable to budget $0.6 million driven by:

- Favorable volume related variance of $0.6 million
- Favorable price related variance of $0.1 million

ADMINISTRATIVE EXPENSES of $2.6 million are favorable to budget $0.7 million driven by:

- Non-Salary expenses favorable to budget $0.5 million
- Salaries, Wages & Employee Benefits expense favorable to budget $0.1 million

CHANGE IN NET ASSETS is ($0.9) million, favorable to budget $0.7 million

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
498	**475**	**23**	**4.8%**	**Member Months**	**2,015**	**1,886**	**129**	**6.8%**
				Revenues				
3,219,200	2,984,987	234,213	7.8%	Medi-Cal Capitation Revenue	12,960,602	11,847,264	1,113,338	9.4%
755,017	714,973	40,044	5.6%	Medicare Part C Revenue	3,066,210	2,869,624	196,586	6.9%
311,803	237,389	74,414	31.3%	Medicare Part D Revenue	1,294,082	945,811	348,271	36.8%
4,286,019	**3,937,349**	**348,670**	**8.9%**	**Total Operating Revenue**	**17,320,895**	**15,662,699**	**1,658,196**	**10.6%**
				Medical Expenses				
1,255,841	1,394,513	138,672	9.9%	Medical Management	4,956,926	5,491,910	534,984	9.7%
1,270,165	752,664	(517,501)	(68.8%)	Facilities Claims	2,920,008	2,955,379	35,371	1.2%
722,435	829,954	107,519	13.0%	Professional Claims	2,525,608	3,256,985	731,377	22.5%
550,907	553,385	2,478	0.4%	Prescription Drugs	2,408,370	2,163,534	(244,836)	(11.3%)
10,888	27,825	16,937	60.9%	MLTSS	30,533	92,729	62,196	67.1%
200,213	260,447	60,234	23.1%	Patient Transportation	873,799	1,041,788	167,989	16.1%
4,010,449	**3,818,788**	**(191,661)**	**(5.0%)**	**Total Medical Expenses**	**13,715,244**	**15,002,325**	**1,287,081**	**8.6%**
275,571	**118,561**	**157,010**	**132.4%**	**Gross Margin**	**3,605,651**	**660,374**	**2,945,277**	**446.0%**
				Administrative Expenses				
178,409	176,911	(1,498)	(0.8%)	Salaries, Wages & Employee Benefits	647,734	693,530	45,796	6.6%
1,552	8,708	7,156	82.2%	Professional Fees	6,136	35,132	28,996	82.5%
37,577	60,033	22,456	37.4%	Purchased Services	189,775	240,132	50,357	21.0%
-	24,525	24,525	100.0%	Printing & Postage	2,251	98,100	95,849	97.7%
971	1,600	629	39.3%	Depreciation & Amortization	3,788	6,400	2,612	40.8%
11,064	12,698	1,634	12.9%	Other Operating Expenses	28,872	50,492	21,620	42.8%
16,321	16,618	297	1.8%	Indirect Cost Allocation, Occupancy	65,283	66,152	869	1.3%
245,894	**301,093**	**55,199**	**18.3%**	**Total Administrative Expenses**	**943,838**	**1,189,938**	**246,100**	**20.7%**
29,677	**(182,532)**	**212,209**	**116.3%**	**Change in Net Assets**	**2,661,813**	**(529,564)**	**3,191,377**	**602.6%**
93.6%	***97.0%***	***(3.4%)***		***Medical Loss Ratio***	***79.2%***	***95.8%***	***(16.6%)***	
5.7%	***7.6%***	***1.9%***		***Admin Loss Ratio***	***5.4%***	***7.6%***	***2.1%***	

CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
506	**568**	**(62)**	**(10.9%)**	**Member Months**	**1,946**	**2,272**	**(326)**	**(14.3%)**
				Revenues				
233,214	253,517	(20,303)	(8.0%)	Revenue	884,594	1,014,068	(129,474)	(12.8%)
233,214	**253,517**	**(20,303)**	**(8.0%)**	**Total Operating Revenue**	**884,594**	**1,014,068**	**(129,474)**	**(12.8%)**
				Medical Expenses				
198,553	207,784	9,231	4.4%	Medical Management	737,829	831,136	93,307	11.2%
42,177	32,957	(9,220)	(28.0%)	Waiver Services	141,834	131,828	(10,006)	(7.6%)
198,553	207,784	9,231	4.4%	Total Medical Management	737,829	831,136	93,307	11.2%
42,177	32,957	(9,220)	(28.0%)	Total Waiver Services	141,834	131,828	(10,006)	(7.6%)
240,729	**240,741**	**12**	**0.0%**	**Total Program Expenses**	**879,663**	**962,964**	**83,301**	**8.7%**
(7,515)	**12,776**	**(20,291)**	**(158.8%)**	**Gross Margin**	**4,931**	**51,104**	**(46,173)**	**(90.4%)**
				Administrative Expenses				
99,056	111,254	12,198	11.0%	Salaries, Wages & Employee Benefits	371,532	436,999	65,467	15.0%
1,417	1,417	0	0.0%	Professional Fees	5,667	5,668	1	0.0%
-	-	-	0.0%	Purchased Services	14	-	(14)	(100.0%)
8,174	8,250	76	0.9%	Other Operating Expenses	29,594	33,000	3,406	10.3%
6,353	7,333	980	13.4%	Indirect Cost Allocation, Occupancy	25,410	29,332	3,922	13.4%
115,000	**128,254**	**13,254**	**10.3%**	**Total Administrative Expenses**	**432,217**	**504,999**	**72,782**	**14.4%**
(122,515)	**(115,478)**	**(7,037)**	**(6.1%)**	**Change in Net Assets**	**(427,286)**	**(453,895)**	**26,609**	**5.9%**
103.2%	***95.0%***	***8.3%***		***Medical Loss Ratio***	***99.4%***	***95.0%***	***4.5%***	
49.3%	***50.6%***	***1.3%***		***Admin Loss Ratio***	***48.9%***	***49.8%***	***0.9%***	

CalOptima Health
Building - 505 City Parkway
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Administrative Expenses				
61,103	22,905	(38,198)	(166.8%)	Purchased Services	195,749	91,620	(104,129)	(113.7%)
181,030	195,000	13,970	7.2%	Depreciation & Amortization	723,389	780,000	56,611	7.3%
24,795	26,654	1,859	7.0%	Insurance Expense	99,178	106,616	7,438	7.0%
131,042	181,186	50,144	27.7%	Repair & Maintenance	463,833	724,744	260,911	36.0%
65,194	56,824	(8,370)	(14.7%)	Other Operating Expenses	312,330	227,296	(85,034)	(37.4%)
(463,163)	(482,569)	(19,406)	(4.0%)	Indirect Cost Allocation, Occupancy	(1,794,478)	(1,930,276)	(135,798)	(7.0%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

CalOptima Health
Building - 500 City Parkway
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
156,423	135,866	20,557	15.1%	Rental Income	625,693	543,464	82,229	15.1%
156,423	**135,866**	**20,557**	**15.1%**	**Total Operating Revenue**	**625,693**	**543,464**	**82,229**	**15.1%**
				Administrative Expenses				
32,005	9,330	(22,675)	(243.0%)	Purchased Services	136,084	37,320	(98,764)	(264.6%)
34,573	51,000	16,427	32.2%	Depreciation & Amortization	138,292	204,000	65,708	32.2%
8,226	8,746	520	6.0%	Insurance Expense	33,173	34,984	1,811	5.2%
111,168	94,592	(16,576)	(17.5%)	Repair & Maintenance	240,859	378,368	137,509	36.3%
33,935	25,978	(7,957)	(30.6%)	Other Operating Expenses	169,567	103,912	(65,655)	(63.2%)
(23,288)	-	23,288	100.0%	Indirect Cost Allocation, Occupancy	(76,035)	-	76,035	100.0%
196,618	**189,646**	**(6,972)**	**(3.7%)**	**Total Administrative Expenses**	**641,940**	**758,584**	**116,644**	**15.4%**
(40,194)	**(53,780)**	**13,586**	**25.3%**	**Change in Net Assets**	**(16,247)**	**(215,120)**	**198,873**	**92.4%**

CalOptima Health
Building - 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
(9,600)	-	(9,600)	(100%)	Rental Income	-	-	-	0.0%
(9,600)	**-**	**(9,600)**	**(100.0%)**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
23,164	42,500	19,336	45.5%	Purchased Services	104,103	170,000	65,897	38.8%
9,397	21,000	11,603	55.3%	Depreciation & Amortization	37,590	84,000	46,410	55.3%
4,751	-	(4,751)	(100.0%)	Insurance Expense	17,995	-	(17,995)	(100.0%)
298	-	(298)	(100.0%)	Repair & Maintenance	1,190	-	(1,190)	(100.0%)
2,935	-	(2,935)	(100.0%)	Other Operating Expenses	5,414	-	(5,414)	(100.0%)
40,545	**63,500**	**22,955**	**36.1%**	**Total Administrative Expenses**	**166,292**	**254,000**	**87,708**	**34.5%**
(50,145)	**(63,500)**	**13,355**	**21.0%**	**Change in Net Assets**	**(166,292)**	**(254,000)**	**87,708**	**34.5%**

OTHER PROGRAM INCOME STATEMENTS – OCTOBER MONTH:

PACE

- **CHANGE IN NET ASSETS** is $29,677, favorable to budget $0.2 million driven primarily by favorable enrollment and Calendar Year (CY) 2024 rate increase

MSSP

- **CHANGE IN NET ASSETS** is ($122,515), unfavorable to budget $7,037

NON-OPERATING INCOME STATEMENTS – OCTOBER MONTH

BUILDING 500

- **CHANGE IN NET ASSETS** is ($40,194), favorable to budget $13,586
  - Net of $156,423 in rental income and $196,618 in expenses

BUILDING 7900

- **CHANGE IN NET ASSETS** is ($50,145), favorable to budget $13,355
  - Net of ($9,600) in rental income due to adjustment and $40,545 in expenses

INVESTMENT INCOME

- Unfavorable variance of $4.7 million due to $8.2 million of interest income and $12.9 million of net realized and unrealized loss on investments due to high interest rates causing a decrease in bond values

CalOptima Health
Balance Sheet
October 31, 2024

	October-24	September-24	$ Change	% Change
ASSETS				
Current Assets				
Cash and Cash Equivalents	636,183,232	594,419,494	41,763,738	7.0%
Short-term Investments	1,594,075,058	1,746,560,045	(152,484,987)	(8.7%)
Premiums due from State of CA and CMS	694,469,640	678,504,967	15,964,673	2.4%
Prepaid Expenses and Other	12,807,822	12,803,262	4,560	0.0%
Total Current Assets	**2,937,535,752**	**3,032,287,768**	**(94,752,016)**	**(3.1%)**
Board Designated Assets				
Board Designated Reserves	1,030,468,550	1,036,123,723	(5,655,173)	(0.5%)
Statutory Designated Reserves	135,091,898	136,448,560	(1,356,662)	(1.0%)
Total Designated Assets	**1,165,560,448**	**1,172,572,283**	**(7,011,835)**	**(0.6%)**
Restricted Deposit	**300,000**	**300,000**	**-**	**0.0%**
Capital Assets, Net	103,588,281	103,887,079	(298,799)	(0.3%)
Total Assets	**4,206,984,481**	**4,309,047,131**	**(102,062,650)**	**(2.4%)**
Deferred Outflows of Resources				
Advance Discretionary Payment	49,999,717	49,999,717	-	0.0%
Net Pension	24,549,290	24,549,290	-	0.0%
Other Postemployment Benefits	1,350,000	1,350,000	-	0.0%
Total Deferred Outflows of Resources	**75,899,007**	**75,899,007**	**-**	**0.0%**
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	**4,282,883,488**	**4,384,946,138**	**(102,062,650)**	**(2.3%)**
LIABILITIES				
Current Liabilities				
Medical Claims Liability	1,132,864,528	1,148,863,597	(15,999,069)	(1.4%)
Provider Capitation and Withholds	146,797,777	174,031,470	(27,233,694)	(15.6%)
Accrued Reinsurance Costs to Providers	7,890,371	6,290,371	1,600,000	25.4%
Unearned Revenue	20,093,256	17,952,241	2,141,015	11.9%
Accounts Payable and Other	272,921,907	336,158,208	(63,236,301)	(18.8%)
Accrued Payroll and Employee Benefits and Other	26,352,023	23,921,387	2,430,636	10.2%
Other Current Liabilities	3,357	6,701	(3,344)	(49.9%)
Total Current Liabilities	**1,606,923,220**	**1,707,223,977**	**(100,300,757)**	**(5.9%)**
GASB 96 Subscription Liabilities	21,387,713	21,616,375	(228,662)	(1.1%)
Community Reinvestment	107,217,960	105,737,300	1,480,660	1.4%
Postemployment Health Care Plan	17,513,725	17,475,895	37,830	0.2%
Net Pension Liability	45,981,359	45,981,359	-	0.0%
Total Liabilities	**1,799,023,976**	**1,898,034,906**	**(99,010,929)**	**(5.2%)**
Deferred Inflows of Resources				
Net Pension	2,248,445	2,248,445	-	0.0%
Other Postemployment Benefits	6,398,000	6,398,000	-	0.0%
Total Deferred Inflows of Resources	**8,646,445**	**8,646,445**	**-**	**0.0%**
Net Position				
Required TNE	132,168,843	131,917,008	251,834	0.2%
Funds in excess of TNE	2,343,044,224	2,346,347,779	(3,303,555)	(0.1%)
Total Net Position	**2,475,213,067**	**2,478,264,787**	**(3,051,720)**	**(0.1%)**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION	**4,282,883,488**	**4,384,946,138**	**(102,062,650)**	**(2.3%)**

Back to Agenda

BALANCE SHEET – OCTOBER MONTH:

ASSETS of $4.3 billion decreased $102.1 million from September or 2.3%

- Operating Cash and Short-term Investments net decrease of $110.7 million due to the quarterly Managed Care Organization (MCO) tax payment of $125.5 million
- Total Designated Assets decreased $7.0 million due to unrealized investment losses due to high interest rates. Long-term rates increased drastically resulting in a decrease in bond values
- Premiums due from State of California (CA) and Centers for Medicare & Medicaid Services (CMS) increased $16.0 million primarily due to timing of cash receipts

LIABILITIES of $1.8 billion decreased $99.0 million from September or 5.2%

- Accounts Payable and Other decreased $63.2 million primarily due to quarterly tax payment offset by the current month accrual
- Provider Capitation and Withholds decreased $27.2 million primarily due to the Medi-Cal Pay-for-Value payout for Measurement Year (MY) 2023
- Medical Claims Liabilities decreased $16.0 million due to timing of claim payments

NET ASSETS of $2.5 billion, decreased $3.1 million from September or 0.1%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of October 31, 2024

Board Designated Reserves

Investment Account Name	Market Value	Benchmark		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	515,362,884				
MetLife Tier One	515,105,666				
Board Designated Reserves	1,030,468,550	946,033,628	1,135,240,354	84,434,921	(104,771,804)
Current Reserve Level (X months of average monthly revenue) [1]	*2.72*	*2.50*	*3.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	Benchmark		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	67,678,927				
MetLife Tier Two	67,412,971				
Statutory Designated Reserves	135,091,899	132,168,843	145,385,727	2,923,056	(10,293,828)
Current Reserve Level (X min. TNE) [1]	*1.02*	*1.00*	*1.10*		

[1] *See CalOptima Health policy GA.3001 Statutory and Board-Designasted Reserve Funds for more information*

CalOptima Health
Statement of Cash Flow
October 2024

	October 2024	July - October 2024
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	(3,051,720)	30,130,892
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation & Amortization	1,026,628	3,857,095
Changes in assets and liabilities:		
Prepaid expenses and other	(4,560)	(1,638,703)
Capitation receivable	(15,964,673)	(139,783,156)
Medical claims liability	(15,257,703)	(12,947,859)
Deferred revenue	2,141,015	4,832,093
Payable to health networks	(26,375,060)	(27,577,284)
Accounts payable	(63,236,301)	100,602,301
Accrued payroll	2,468,465	609,080
Other accrued liabilities	1,248,654	4,960,152
Net cash provided by/(used in) operating activities	(117,005,255)	(36,955,389)
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	152,484,987	183,820,882
Change in Property and Equipment	(727,829)	(10,884,568)
Change in Restricted Deposit & Other	-	-
Change in Board designated reserves	7,011,835	(27,797,010)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	158,768,993	145,139,303
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	41,763,738	108,183,915
CASH AND CASH EQUIVALENTS, beginning of period	594,419,494	527,999,317
CASH AND CASH EQUIVALENTS, end of period	**636,183,232**	**636,183,232**

CalOptima Health
Spending Plan
For the Four Months Ending October 31, 2024

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 10/31/2024	**$2,475.2**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,030.5**			**41.6%**
	Statutory Designated Reserve[1]	**$135.1**			**5.5%**
	Capital Assets, net of Depreciation[2]	**$103.6**			**4.2%**
Resources Allocated[3]	Homeless Health Initiative[3]	$16.8	$61.7	44.9	0.7%
	Housing and Homelessness Incentive Program[3]	22.2	87.4	65.1	0.9%
	Intergovernmental Transfers (IGT)	54.9	111.7	56.8	2.2%
	Digital Transformation and Workplace Modernization[4]	49.5	100.0	50.5	2.0%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	CalFresh Outreach Strategy	0.1	2.0	1.9	0.0%
	CalFresh and Redetermination Outreach Strategy	2.1	6.0	3.9	0.1%
	Coalition of Orange County Community Health Centers Grant	30.0	50.0	20.0	1.2%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	0.2	0.5	0.3	0.0%
	General Awareness Campaign	1.3	4.7	3.4	0.1%
	Member Health Needs Assessment	1.1	1.3	0.2	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	131.6	153.5	21.9	5.3%
	Medi-Cal Annual Wellness Initiative	2.5	3.8	1.3	0.1%
	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	3.5	5.0	1.5	0.1%
	Community Living and PACE center (previously approved for project located in Tustin)	17.6	18.0	0.4	0.7%
	Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program Grant	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	45.6	50.0	4.4	1.8%
	Distribution Event- Naloxone Grant	2.3	15.0	12.7	0.1%
	Garden Grove Bldg. Improvement	10.0	10.5	0.5	0.4%
	Post-Pandemic Supplemental	7.3	107.5	100.2	0.3%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.5%
	Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
	Outreach Strategy for newly eligible Adult Expansion members	5.6	7.6	2.0	0.2%
	Quality Initiatives from unearned Pay for Value Program	23.3	23.3	0.0	0.9%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.7	1.0	0.3	0.0%
	Medi-Cal Provider Rate Increases	456.0	526.2	70.2	18.4%
	Subtotal:	**$937.4**	**$1,422.3**	**$484.8**	**37.9%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$268.6**			**10.9%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 122 days of CalOptima Health's current operations
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements
[3] See HHI and HHIP summaries and Allocated Funds for list of Board approved initiatives. Amount reported includes only portion funded by reserves
[4] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024

CalOptima Health
Key Financial Indicators
As of October 31, 2024

	Item Name	October 2024 Actual	Budget	Variance	%		July - October 2024 Actual	Budget	Variance	%	
Income Statement	*Member Months*	910,063	898,380	11,683	1.3%		3,650,442	3,604,985	45,457	1.3%	
	Operating Revenue	367,350,155	354,890,555	12,459,600	3.5%		1,623,301,815	1,422,996,834	200,304,981	14.1%	
	Medical Expenses	349,543,471	364,859,583	15,316,112	4.2%		1,586,004,481	1,424,725,597	(161,278,884)	(11.3%)	
	General and Administrative Expense	22,721,241	24,615,739	1,894,498	7.7%		79,207,551	96,381,292	17,173,741	17.8%	
	Non-Operating Income/(Loss)	1,862,835	5,370,555	(3,507,720)	(65.3%)		72,041,110	21,573,129	50,467,981	233.9%	
	Summary of Income & Expenses	(3,051,720)	(29,214,212)	26,162,492	89.6%		30,130,892	(76,536,926)	106,667,818	139.4%	
Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	95.2%	102.8%	(7.7%)			97.7%	100.1%	(2.4%)		
	Administrative Loss Ratio (ALR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	6.2%	6.9%	0.8%			4.9%	6.8%	1.9%		

Key:
> 0%
> -20%, < 0%
< -20%

Investment	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
	@10/31/2024	2,738,497,921	2,888,632,805	(150,134,884)	(5.2%)

Unallocated/Unassigned Reserve Balance	Current Month @ October 2024	Fiscal Year Ending June 2024	Change	%
Consolidated	268,629,659	187,643,914	80,985,745	43.2%
*Days Cash On Hand**	122			

*Total Designated Reserves and unallocated reserve amount can support approximately 122 days of CalOptima Health's current operations.

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CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Four Months Ending October 31, 2024

	October 2024				July - October 2024				All Time to Date			
	Actual Spend	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**
Capital Assets (Cost, Information Only):												
Total Capital Assets	**359,647**	**127,699**	**(231,948)**	**(181.6%)**	**2,157,650**	**443,378**	**(1,714,272)**	**(386.6%)**	**10,600,510**	**24,444,087**	**13,843,577**	**56.6%**
Operating Expenses:												
Salaries, Wages & Benefits	572,863	589,848	16,985	2.9%	2,209,564	2,359,392	149,828	6.4%	13,215,831	13,365,659	149,828	1.1%
Professional Fees	1,279,231	519,319	(759,912)	(146.3%)	2,122,022	2,087,944	(34,078)	(1.6%)	3,883,085	3,849,007	(34,078)	(0.9%)
Purchased Services	3,838	142,000	138,162	97.3%	108,019	568,000	459,982	81.0%	258,019	718,000	459,982	64.1%
GASB 96 Amortization Expenses	46,878	293,417	246,539	84.0%	187,511	1,173,668	986,157	84.0%	2,158,714	3,144,871	986,157	31.4%
Other Expenses	1,302,057	751,444	(550,613)	(73.3%)	3,226,840	2,995,108	(231,733)	(7.7%)	16,756,332	16,524,600	(231,733)	(1.4%)
Medical Management	229,256	-	(229,256)	0.0%	917,026	-	(917,026)	0.0%	3,668,104	2,751,078	(917,026)	(33.3%)
Total Operating Expenses	**3,434,123**	**2,296,028**	**(1,138,095)**	**(49.6%)**	**8,770,982**	**9,184,112**	**413,130**	**4.5%**	**39,940,085**	**40,353,215**	**413,130**	**1.0%**

Funding Balance Tracking:	**Approved Budget**	**Actual Spend**	**Variance**
Beginning Funding Balance	100,000,000	100,000,000	-
Less:			
Capital Assets[1]	31,525,709	10,600,510	20,925,199
FY2023 Operating Budget[2]	8,381,011	8,381,011	-
FY2024 Operating Budget	22,788,092	22,788,092	-
FY2025 Operating Budget	27,552,335	8,770,982	18,781,353
Ending Funding Balance	**9,752,853**	**49,459,405**	**39,706,552**
Add: Prior year unspent Operating Budget	-		
Total available Funding	**9,752,853**		

[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, Subscription.

CalOptima Health
Summary of Homeless Health Initiatives (HHI) and Allocated Funds
As of October 31, 2024

Funds Allocation, approved initiatives:	**Allocated Amount**	**Utilized Amount**	**Remaining Approved Amount**
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	833,313	129,948
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,758,740	6,130,173
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine[1]	10,076,652	6,666,754	3,409,898
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[2]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$101,800,000**	**$44,917,760**	**$56,882,240**
Transfer of funds to HHIP[2]	(40,100,000)	-	(40,100,000)
Program Total	**$61,700,000**	**$44,917,760**	**$16,782,240**

Notes:

[1]On March 7, 2024, CalOptima Health's Board of Directors approved $5M. $3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and $1.8 million from existing reserves to fund 2-year agreements to Healthcare in Action and Celebrating Life Community Health Center

[2]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP

CalOptima Health

Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds

As of October 31, 2024

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	35,200,994	28,876,725	6,324,269	37,730,195[1]
Existing Reserves & HHI Transfer	87,384,530	87,384,530	65,134,997	22,249,533	-
Total	**160,315,719**	**122,585,524**	**94,011,722**	**28,573,802**	**37,730,195**

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	800,000	692,350	107,650	HHI
Consultant	600,000	-	600,000	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	3,271,805	749,507	HHI & DHCS
Infrastructure Projects	5,832,314	5,391,731	440,583	HHI
Capital Projects	98,247,369	77,195,575	21,051,794	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	4,863,856	5,320,674	DHCS
Non-Profit Healthcare Academy	700,000	396,404	303,596	DHCS
Total of Approved Initiatives	**$122,585,524[1]**	**$94,011,721**	**$28,573,803**	

Notes:

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments

CalOptima Health
Budget Allocation Changes
Reporting Changes as of October 2024

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	ITS - Applications Management - System Development Enhancement for CalAIM	ITS - Applications Management - Care Management System - ZeOmega JIVA	$249,000	To reallocate funds from ITS - Applications Management - System Development Enhancement for CalAIM to Care Management System – ZeOmega JIVA for reporting post Go Live.	2024-25
July	Medi-Cal	Accounting - Purchased Services	Accounting - Printing and Postage	$20,000	To reallocate funds from Accounting - Purchased Services to Accounting – Printing and Postage to provide additional funding for toner purchase.	2024-25
August	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - VMWare	ITS - Infrastructure - Other Operating Expenses - IT Service Management	$38,490	To reallocate funds from ITS - Infrastructure - Maintenance HW/SW - Server - VMWare to IT Service Management to address additional licensing needs and increased costs for the Impact Guide.	2024-25
August	Medi-Cal	IS - Applications Management - Professional Fees - Salesforce CRM	ITS - Applications Management - Other Operating Expenses - Crowe Subscription License Fee	$38,500	To reallocate funds from ITS - Applications Management - Salesforce CRM to Crowe Subscription License Fee to provide funding needed for its licensing.	2024-25
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Infrastructure - Network Bandwidth Upgrade for All Sites (Wide Area Network)	$10,349	To reallocate funds from ITS - Infrastructure - Modern Customer Contact Center to Network Bandwidth Upgrade for All Sites (Wide Area Network) due to increase in expenses.	2024-25
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Application Development - Digital Transformation Strategy Planning and Execution Support	$32,425	To reallocate funds from ITS - Infrastructure - Modern Customer Contact Center to Digital Transformation Strategy Planning and Execution Support due to increase in expenses.	2024-25
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Applications Management - Clinical Data Sets Quality Assurance & Data Aggregator Validation	$70,000	To reallocate funds from ITS - Infrastructure - Modern Customer Contact Center to Clinical Data Sets Quality Assurance & Data Aggregator Validation due to increase in expenses.	2024-25
August	Medi-Cal	ITS - Application Development - Other Operating Expenses - Veracode Code Scanning	Executive Office - Other Operating Expenses - CEO Leadership Alliance of Orange County (CLAOC)	$40,000	To reallocate funds from ITS - Application Development - Veracode Code Scanning to Executive Office - CEO Leadership Alliance of Orange County (CLAOC) Associations dues.	2024-25
September	OneCare	Communications - Purchased Services - Advertising	Communications - Professional Fees	$144,000	To reallocate funds from Communications - Advertising - Outdoor to Professional Fees to provide additional funding for Runyon Saltzman for Marketing.	2024-25
September	Medi-Cal	ITS - Applications Management - Other Operating Expenses - HW/SW Maintenance	Executive Office - Other Operating Expenses - Professional Dues	$50,000	To reallocate funds from ITS - Applications Management - HW/SW Maintenance to Executive Office - Professional Dues for coverage of expenses.	2024-25
September	Medi-Cal	Accounting - Purchased Services	Accounting - Other Operating Expenses - Office Supplies	$15,000	To reallocate funds from Accounting - Change Health Care - Claims Processing/Mailing to Office Supplies to provide additional funding needed to replenish check stock.	2024-25
September	PACE	PACE Administrative - Professional Fees	PACE Administrative - Other Operating Expenses - Subscriptions	$15,000	To reallocate funds from PACE Administrative - DHCS Annual Fee to Subscriptions to provide funding for DHCS PACE Licensing Fees.	2024-25
September	Medi-Cal	ITS - Application Development - Other Operating Expenses - HW/SW Maintenance	ITS - Applications Management - Other Operating Expenses - Care Management System - HealthEdge	$158,000	To reallocate funds from ITS - Application Development - Capital Software Expense to ITS - Applications Management - HealthEdge to help pay for Guiding Care Read Only invoice.	2024-25
September	OneCare	Sales & Marketing - Purchased Services	ITS - Applications Management - Professional Fees	$50,000	To reallocate funds from Sales & Marketings - Purchased Services - General to ITS - Applications Management – Enthrive to engage Enthrive for additional builds to the agent portal.	2024-25
September	Medi-Cal	ITS - Infrastructure - Professional Fees	ITS - Infrastructure - Other Operating Expenses - Subscriptions	$32,000	To reallocate funds from ITS - Infrastructure - MSFT Azure Assistance to Delphix - Continuous Data FACETS to cover the renewal subscription being higher than the anticipated amount.	2024-25

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
December 5, 2024

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. California State Auditor – Joint Legislative Audit Committee (JLAC) Audit

Update

- On November 13, 2024, the California State Auditor (CSA) updated the CSA website to show that all seven recommendations have been "Fully Implemented".

Previously Reported

- October 22, 2024, the California State Auditor (CSA) confirmed that CalOptima Health has fully implemented all audit recommendations and has officially closed the audit with no further responses or actions required.
- CSA indicated it expects to formally publish the final audit status on its website within two weeks of October 22, 2024.
- As a recap, CSA released a report on May 2, 2023, following a comprehensive nine-month audit of CalOptima Health that covered an eight-year period from January 2014 through June 2022. 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 regarding the implementation of the report's seven recommendations.
- As of the one-year update submitted on May 2, 2024, four of the seven audit recommendations required further updates.
- CSA reviewed the updates for the four recommendations and provided notification via email to CalOptima Health on October 22, 2024, that the four remaining recommendations were accepted as fully implemented.
- ALL the recommendations have been successfully completed and closed.

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2. Medicare

a. Calendar Year (CY) 2022 Centers for Medicare & Medicaid Services (CMS) 1/3 Financial Audit (*applicable to OneCare)*

Update

- Dember 11, 2024 -- Due date for corrective action plan (CAP) reporting remediation of all findings.
- CalOptima Health Regulatory Affairs & Compliance (RAC) is currently working with the business areas to finalize all CAP documents.

Previously Reported

- CMS is required by statute to audit at least one-third of Medicare Advantage (MA) organizations' financial records each year which will include data relating to Medicare utilization, costs and development of the bid.
- CMS notified CalOptima Health that its OneCare plan had been selected for the CY 2022 CMS Financial Audit and Davis Farr LLP (CPA firm) will conduct the audit. Davis Farr LLP acted in the capacity of CMS agents and requested records and supporting documentation for, but not limited to, the following items:
  - Claims data
  - Solvency
  - Enrollment
  - Base year entries on the bids
  - Medical and/or drug expenses
  - Related party transactions
  - General administrative expenses
  - Direct and Indirect Remuneration (DIR)

Note: The findings described below pertain to a portion of the samples tested.

- September 12, 2024 – CalOptima Health received the Final Audit Report, which included two (2) Findings and two (2) Observations.
  - Finding #1: Section E, Medicare Secondary Payer (MSP) – The Plan did not coordinate benefits with other insurers and paid claims as primary when they should have been paid as secondary.
  - Finding #2: Section F, General Payments to Medical Service Providers-Copayments/Coinsurance were not in accordance with the Plan Benefit Package (PBP).
  - Observation #1: Section A, Bid Reconciliation – The Plan underestimated Direct and Indirect Remuneration (DIR) in the Part D Bid.
  - Observation #2: Section E, Part B Drugs – The Plan paid Prescription Drug Events (PDEs) under Part D when they should have been paid under Part B.

b. 2024 Compliance Program Effectiveness (CPE) Audit

Update

- November 12, 2024 – Final Audit report received
  - No audit findings or observations noted.

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Previously Reported

- 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 its 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 outlined in the CMS Medicare Parts C and D Program Audit Protocols.
- The audit commenced in early August and continued through November 2024.

c. 2025 Department of Managed Care (DMHC) Routine Financial Examination*:*

Update

- Regulatory Affairs and Compliance (RAC) Medicare is continuing work with the areas impacted to ensure audit readiness.
- Audit to be conducted via audio/video conference January 13, 2025, through January 24, 2025.

Previously Reported

- Pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act, the DMHC is responsible for conducting routine financial examinations of each health plan and issuing a public report for each plan.
- The purpose of the financial examinations is to evaluate and report on regulatory compliance with the Knox Keene Act. Each financial examination discusses plan performance in the areas of health plan fiscal and administrative functions.
- September 5, 2024 – the DMHC engaged CalOptima Health for the 2025 DMHC Routine Examination.
    - The examination will be of the Plan's fiscal and administrative affairs, including an examination of CalOptima Health's financial reports.
- December 16, 2024 – Pre-audit deliverables due to DMHC
- January 13, 2025 – Examination to commence and will be conducted remotely via audio/video conference.
- Regulatory Affairs and Compliance (RAC) Medicare has provided a copy of the Entrance Letter and pre-audit deliverables to the business areas and will continue to work with the areas impacted to ensure audit readiness.

d. **2025 CMS Readiness Checklist *(applicable to OneCare)***

Update

- October 30, 2024 – CMS released the 2025 CMS Readiness Checklist.
    - CalOptima Health is expected to fulfill key operational requirements summarized in the readiness checklist for 2025 benefit year.
- RAC Medicare is leading the 2025 Readiness Checklist activities with all applicable departments to ensure compliance for requirements impacting their respective operational area(s).

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Background

- The 2025 CMS Readiness Checklist summarized a subset of key operational requirements solely for the purpose of providing a tool to be used in preparation for the upcoming year. It does not supersede requirements established in statutes or regulations as they related to Medicare Advantage Organizations (MAOs), Prescription Drug Plans (PDPs), 1876 Cost Plans and PACE. CMS recommends that organizations review this checklist and take necessary steps to fulfill requirements for CY 2025.

2. Medi-Cal

a. 2025 Department of Health Care Services (DHCS) Routine Medical Audit

- October 23, 2024 – DHCS engaged CalOptima Health in its annual, routine medical audit.
  - The audit will consist of an evaluation of CalOptima's compliance with its contract and regulations in six (6) categories:
    - Utilization management
    - Case management and coordination of care
      - New area to be audited in this category:
        - Enhanced Care Management (ECM)
    - Availability and accessibility
    - Member's rights
    - Quality management
    - Administrative and organizational capacity
      - New area to be audited in this category:
        - Encounters
  - New areas to be audited
    - Enhanced Care Management (ECM)
    - Encounters
  - The audit is considered a limited-scope audit and requires the participation of two (2) CalOptima Health Networks: Children's Hospital of Orange County Health Alliance (CHOC) and Optum for UM only
  - Onsite interviews will be 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 will involve a review of pre-onsite documents, staff interviews and medical record review.
- December 6, 2024 – Pre-onsite documents due to DHCS
- January 27, 2025 through February 7, 2025 – DHCS begin the onsite visit with an Entrance Conference and conduct staff interviews throughout the rest of the onsite visit.
- Regulatory Affairs and Compliance (RAC) Medi-Cal has provided deliverables and assignments to impacted business areas and will continue to work with them to ensure audit readiness.

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b. 2024 DHCS Routine Medical Audit

Update

- December 15, 2024 – next monthly update due to DHCS.
- November 15, 2024 - CalOptima Health provided its monthly update to DHCS.

Previously Reported

- August 22, 2024 – CalOptima Health received a formal request for corrective action plan (CAP) from DHCS.
- September 23, 2024 – CalOptima Health provided its timely Corrective Action Plan (CAP) submission to DHCS.
  - CalOptima Health is required to submit monthly updates, on the 15th of each month, to DHCS until the final CAP deliverable is completed.
  - Final CAP deliverable is scheduled to be completed by January 2025.
    - October 15, 2024 – CalOptima Health provided its first monthly update to DHCS following the initial CAP submission in September.
- For background the DHCS Routine Medical Audit consists of DHCS's review of both the Primary (aka "Main Contract") and Secondary contracts (aka "State Supported Services"). The findings are as follows:
  - Primary/Main Contract
    - Draft & Final Report Identified **10 Findings**
  - Secondary Contract - State Supported Services (SSS)
    - Draft & Final Report Identified **No Findings**

c. 2023 DHCS Routine Medical Audit (Focused Scope)

Update

- October 7, 2024 – CAP response was submitted timely to DHCS.
- CalOptima Health is currently awaiting DHCS's response.

Previously Reported

- In 2022, DHCS notified all Medi-Cal managed care health plans (MCPs) that it would be conducting focused audits to assess performance in certain identified high-risk areas. DHCS scheduled these focused audits concurrently with the routine annual medical audit. CalOptima Health's annual audit was conducted in February-March 2023 and the corresponding CAP was closed on 12/29/23; the draft report with findings for the *focused audit* were issued 6/19/24.
- CalOptima Health submitted its response to DHCS on Tuesday, July 9, 2024, and did not dispute the contents of the draft report.
- The areas reviewed and results are as follows:

▪ **Audit Period:** 2/1/22-1/31/23 ▪ **Audit Dates:** 2/27/23-3/10/23 ▪ **Draft Report Date:** 6/19/24	
▪ **Transportation** o Non-Emergency Medical Transportation (NEMT) o Non-Medical Transportation (NMT)	No findings

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▪ **Behavioral Health** o Specialty Mental Health Services (SMHS) o Non-Specialty Mental Health Services (NSMHS) o Substance Use Disorder Services (SUDS)	Two Findings

B. Regulatory Notices of Non-Compliance

- CalOptima Health did not receive any notices of non-compliance from its regulators for the month of October 2024.

C. Updates on Health Network Monitoring and Audits

a. Health Network Audits

- CalOptima Health's Delegation Oversight (DO) department completed annual audits on the following delegated health networks to assess their capabilities and performance with delegated activities:
  - Heritage Provider Network – Regal Medical Group – Lookback: June 1, 2023, to June 30, 2024

D. Internal Audit Department

a. Internal Audits

- 2024 Grievances and Appeals (OneCare) Annual Audit
  - Final Results and CAPs issued on 10/24/2024
  - CAP response due from department by 11/8/2024
- 2024 Grievances and Appeals (Medi-Cal) Annual Audit
  - Preliminary Results shared with the GARs department on 10/29/2024
  - Department rebuttal response due by 11/5/2024
- 2024 Utilization Management (OneCare) Annual Audit
  - File selections received from UM dept on 10/21/2024
  - Webinars will occur on 11/13/24 and 11/14/2024
- 2024 Utilization Management (Medi-Cal) Annual Audit
  - Part 1 of Universe data submission is due on 11/27/2024
  - Part 2 of Universe data submission is due after DHCS audit file selections are known
- 2024 Behavioral Health Department Annual Audit
  - Audit engaged on 10/15/2024
  - Initial evidence due back on 11/13/2024
  - Webinar week will commence on 12/16/2024
- 2024 Case Management Department Annual Audit
  - Audit engaged on 10/28/2024
  - Initial evidence due back on 11/27/2024
  - Webinar week will commence on 12/30/2024

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b. Board-Approved Initiatives Review

Update:

- Be Well/Mind OC, Orange
  - GRANT CLOSED 9/30/24
  - Consultant has completed a preliminary close-out review
  - Preliminary review is being updated based on new reporting material received from the Grantee
- Be Well/Mind OC, Irvine
  - GRANT IN PROCESS
  - Consultant review conducted through August 31, 2024
  - Review continues as further materials are received from the Grantee

Previously Reported

- CalOptima Health's Internal Audit department is currently in the process of reviewing CalOptima Health's Board-approved initiatives. Internal Audit's goal is to identify opportunities to strengthen the oversight of the fund's surplus expenditure management process, including the structure for reviewing and signing off on grant programs and initiatives as they are completed.
- Renewal of Ankura Consulting's engagement received Board approval at the September 5, 2024, Board of Directors meeting.
- Phase II Scope of Work includes assistance to implement phase I recommendations and close-out review of grants as they are completed.

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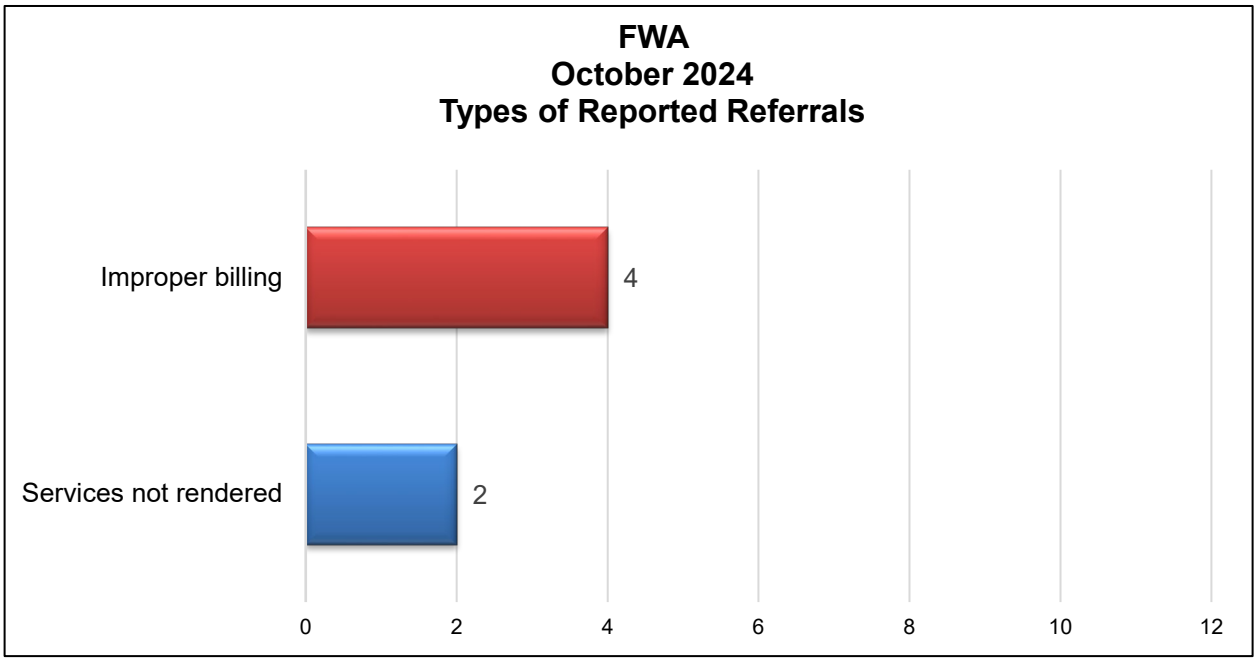
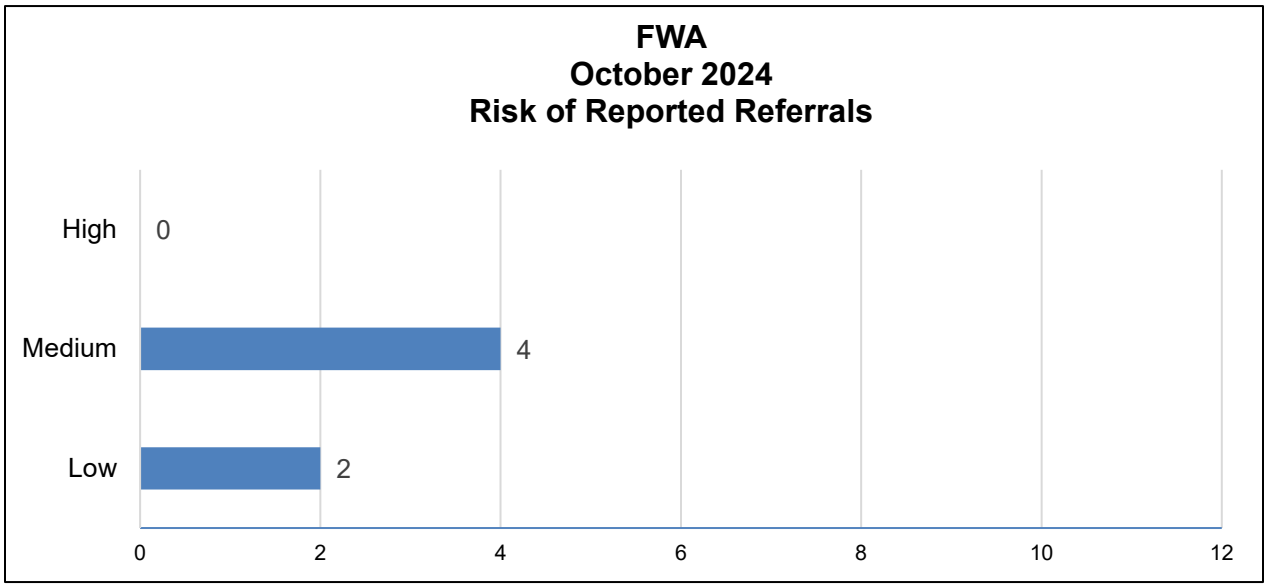
E. Fraud, Waste & Abuse (FWA) Investigations (October 2024)





Total Number of New Cases Referred to DHCS (State)	6
Total Number of New Cases Referred to DHCS and CMS	6
Total Number of Referrals Reported	**6**

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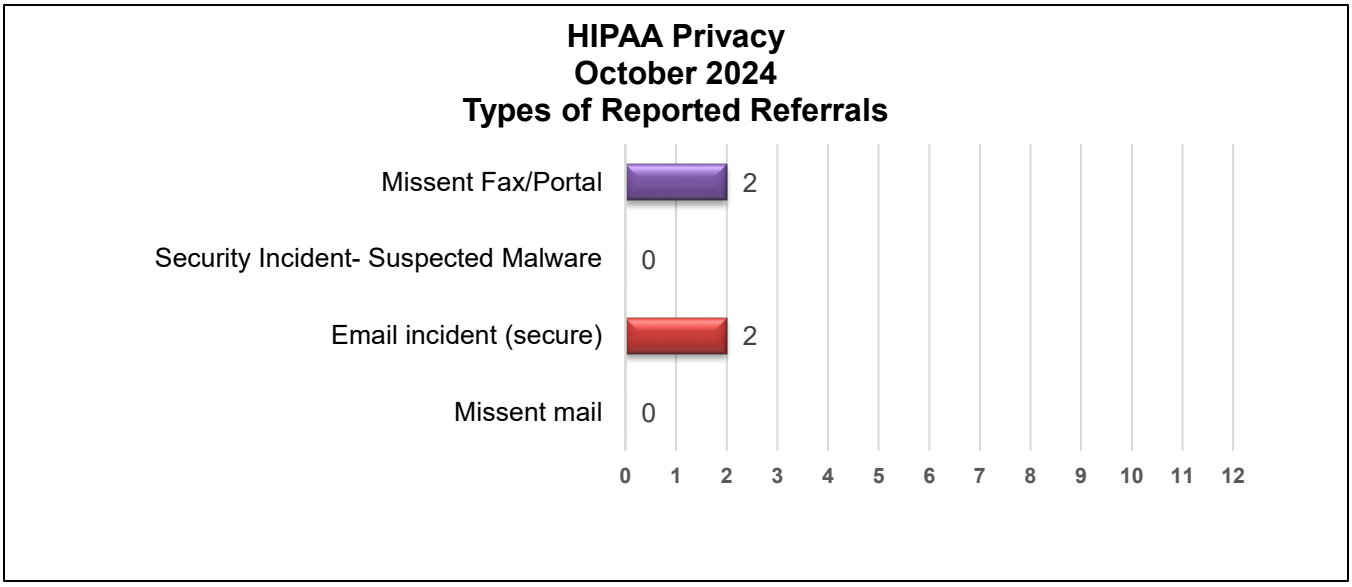
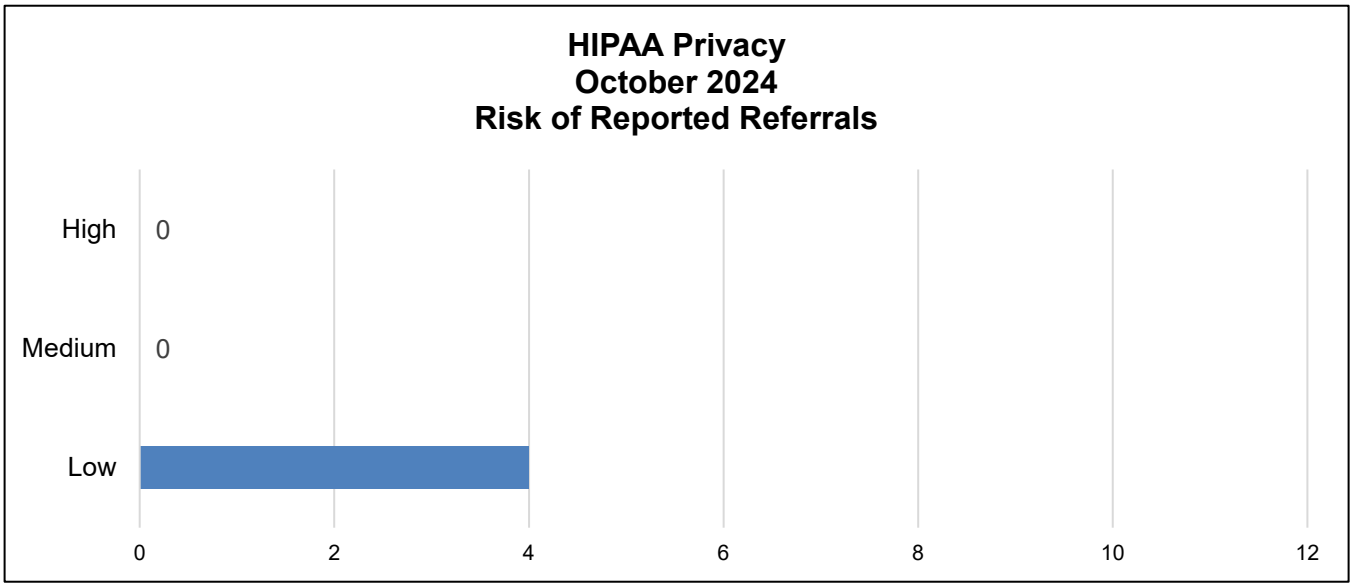
F. Privacy Update (October 2024)





Total Number of Referrals Reported to DHCS (State)	4
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

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Grievance and Appeals Resolution Services (GARS) Member Trend Report Second Quarter 2024

Board of Directors Meeting

December 5, 2024

Tyronda Moses, Director, Grievances and Appeals Resolution Servicers

Our Mission

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

Our Vision

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

Agenda

- Definitions
- Executive Summary
- Grievance Volume and Trends
- Grievance Actions Taken
- Appeals Volume and Types
- Appeals Actions Taken

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Definitions

- Grievance: An expression of dissatisfaction with any aspect of a CalOptima Health program, provider or representative.

- Appeal: A request by the member or on the member's behalf for the review of any decision to deny, modify or discontinue a covered service.

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Executive Summary

- CalOptima Health received a total of 4,593 grievances and 423 appeals for the Medi-Cal and OneCare lines of business combined. The turnaround times for both grievances and appeals are compliant with regulatory standards, averaging a closure rate of 25 days (regulatory requirement is 30 days).
- Grievances
  - Medi-Cal grievances in second quarter were at 4,170. A portion of the trends were related to the transition of transportation service vendors. Other trends were related to delays in referrals and authorizations and dissatisfaction with plan staff or providers.
  - OneCare grievances in second quarter were at 423 with trending down of issues related to access to care and billing services.

Executive Summary (Continued)

- Appeals

  - For the Medi-Cal program, we received 356 appeals, with an overturn rate of 35%. The overturn rate is related to Applied Behavior Analysis (ABA) appeals, tertiary level specialty care appeals and appeals for services related to continuity of care.

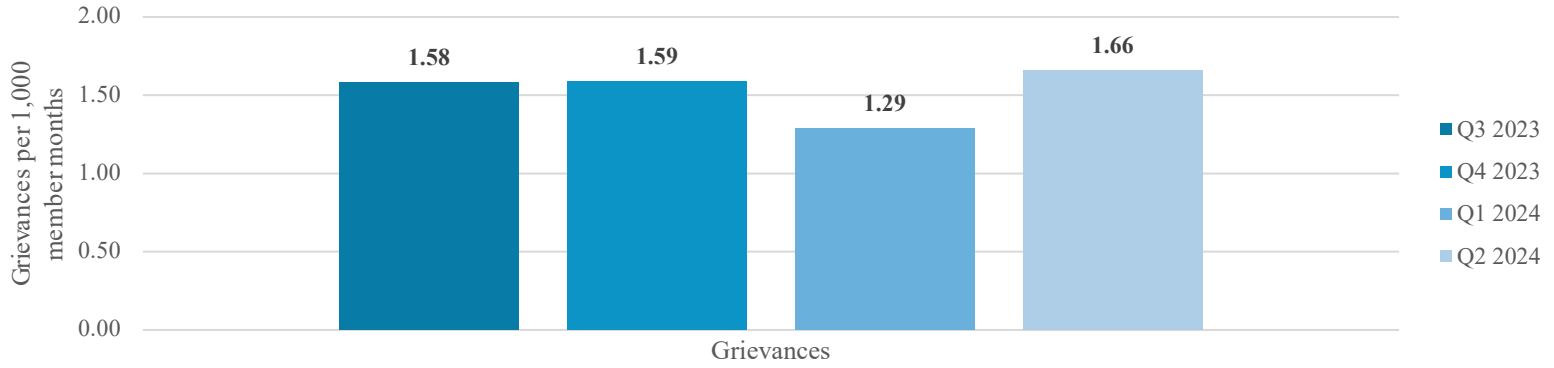
  - For the OneCare program, we received 67 appeals with an overturn rate of 40%. The overturn rate is related to continuity of care and tertiary level specialty care services.

Grievances

Grievance Volume and Compliance

Timeframe	Total Grievances
Q3 2023	4,671
Q4 2023	4,585
Q1 2024	3,596
Q2 2024	4,593

Grievance: Any expression indicating dissatisfaction with any aspect of a CalOptima Health program, provider or representative.



Note: Turnaround Time (TAT) Remains Compliant

Complaint Type	Required TAT	CalOptima Average TAT	Compliance Percentage
Grievances	30 Days	25 Days	99%

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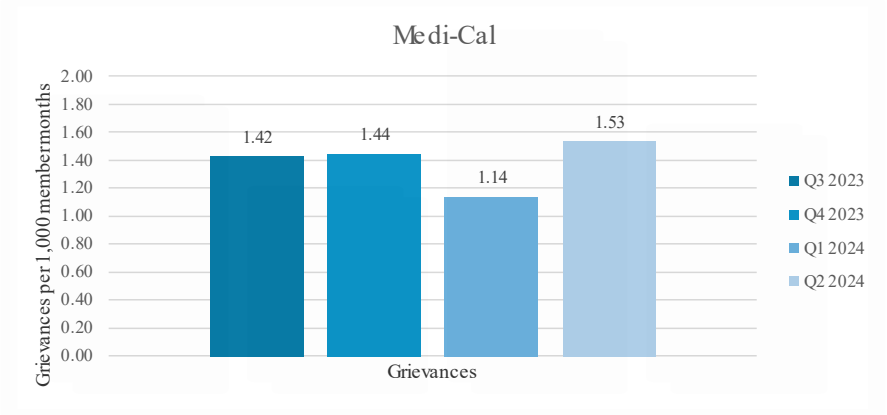
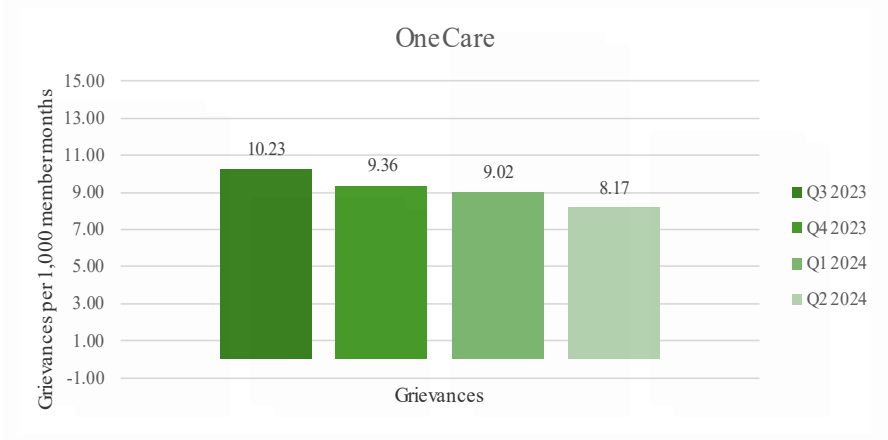
Grievance Volume by Line of Business





Q2 2024	4,170
Q1 2024	3,127
Q4 2023	4,090
Q3 2023	4,126

Q2 2024	423
Q1 2024	469
Q4 2023	495
Q3 2023	545

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CalOptima Health Comparison

- National Committee for Quality Assurance (NCQA) benchmark for grievances is 5, meaning we should receive less than 5 grievances per 1,000 member months

- DHCS rolling average across all similar plans is 3.1 grievances per 1,000 member months. Please note that DHCS delays publication by a few quarters

- CalOptima Health remains below both the industry average and the NCQA benchmark at 1.97 grievances per 1,000 member months

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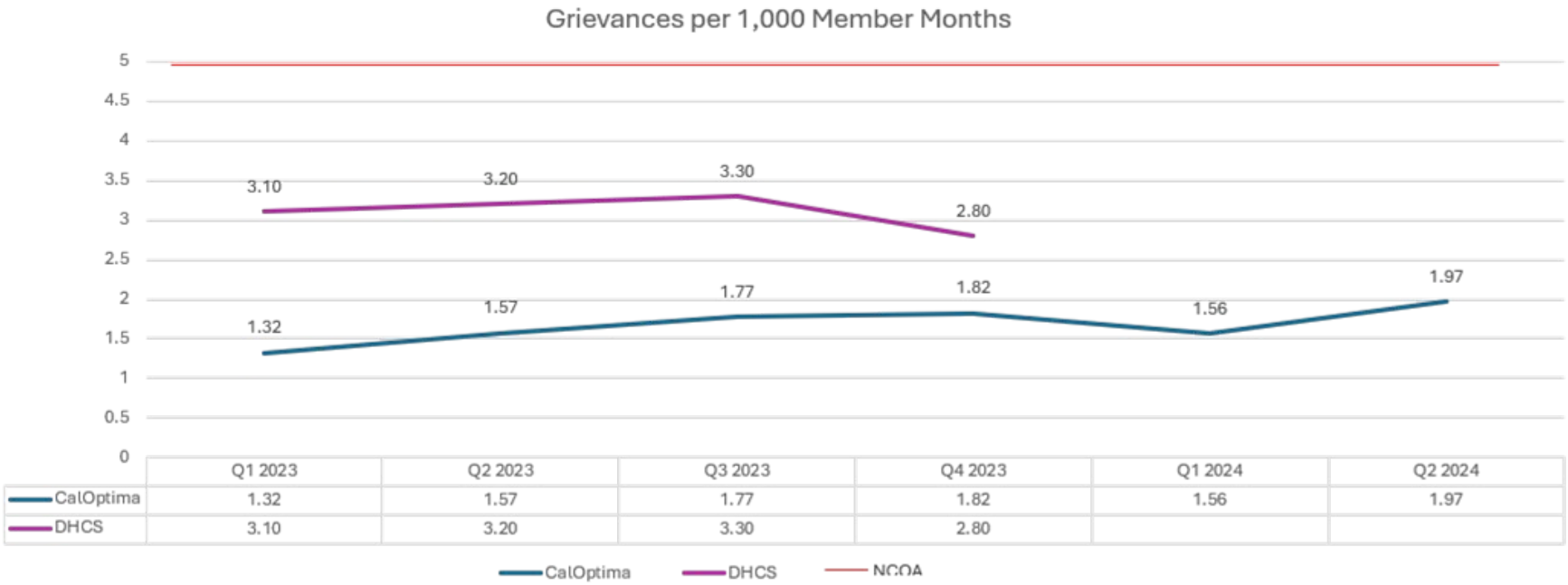
CalOptima Health Comparison (Continued)



	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024
CalOptima	1.32	1.57	1.77	1.82	1.56	1.97
DHCS	3.10	3.20	3.30	2.80		

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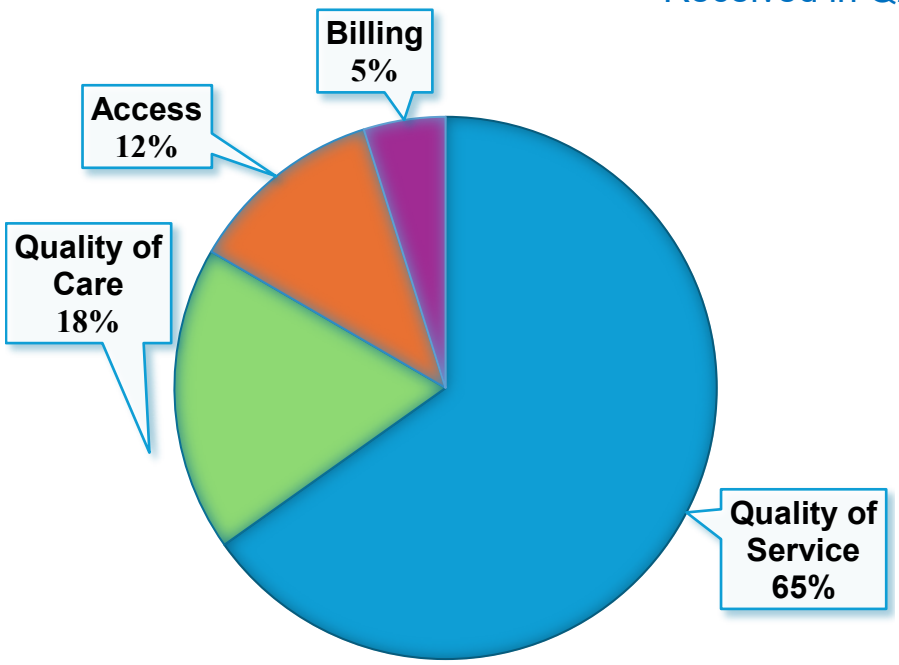
Overall Grievance Types (Medi-Cal and OneCare)

Received in Q2 2024



Type	Volume
Quality of Service	2,994
Quality of Care	539
Access	836
Billing	224

Quality of Service (QOS): Issues that result in member inconvenience or dissatisfaction.
Quality of Care (QOC): Concerns regarding care the member received or feels should have been received.
Access: Concerns regarding accessing care. This includes physically accessing a provider, provider availability, timely access, language access and geographical location.
Billing: Concerns regarding direct member billing and provider balance billing for covered services.

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Grievance Type by Line of Business 2024

	Medi-Cal Q1 2024	Medi-Cal Q2 2024	OneCare Q1 2024	OneCare Q2 2024
Quality of Service	2,034	2,668	366	326
Quality of Care	320	505	27	34
Access	594	789	54	47
Billing	190	208	22	16
Total	3,127	4,170	469	423

Quarter 2 Total	**4,593**
Quarter 1 Total	3,607

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Medi-Cal Grievance Trends for Q2 2024

Quality of Service

Trend	Percentage of Total Volume
Provider/Staff Attitude	11%
Plan's Customer Service	9%
Scheduling	6%

Access

Trend	Percentage of Total Volume
Provider Availability	3%
Scheduling	2%
Timely Access	2%

Quality of Care

Trend	Percentage of Total Volume
Quality of Care	7%
Inappropriate Care	1%
Driver Punctuality	1%

Billing

Trend	Percentage of Total Volume
Provider Direct Member Billing	3%
Reimbursement Request	1%
Provider Balance Billing	0.2%

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OneCare Grievance Trends for Q2 2024

Quality of Service

Trend	Percentage of Total Volume
Driver Punctuality	23%
Provider/Staff Attitude	16%
Scheduling	7%

Quality of Care

Trend	Percentage of Total Volume
Quality of Care	3%
Inappropriate Care	2%
Driver Punctuality	1%

Access

Trend	Percentage of Total Volume
Technology/Telephone	2%
Timely Access	2%
Referral Related	1%

Billing

Trend	Percentage of Total Volume
Provider Balance Billing	1%
Provider Direct Member Billing	1%
Reimbursement Request	1%

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Actions Taken in Response to the Trends

- **Transportation**: Punctuality, Scheduling, Customer Service, Quality of Care
  - Transportation vendor terminated contracts with providers with consistent punctuality issues
  - Addressed scheduling challenges (some confusion in April with services/trips availability)
  - Updated the interactive voice phone system to provide language preferences
  - Collaboration calls between vendor and CalOptima Health (weekly and as needed)

- **Medically Tailored Meals**: Timely Access, Plan Customer Service
  - Trending food providers with service issues were terminated
  - Vendor hired additional staff to address the timely access issues

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Actions Taken in Response to the Trends (Continued)

- **Provider Access**: Timely Access, Provider Availability, Scheduling, Technology/Telephone
  - Network Management completed provider outreach to educate three provider clinics on access standards, securing commitments from the providers for improvement
  - GARS continues to monitor for additional trending providers

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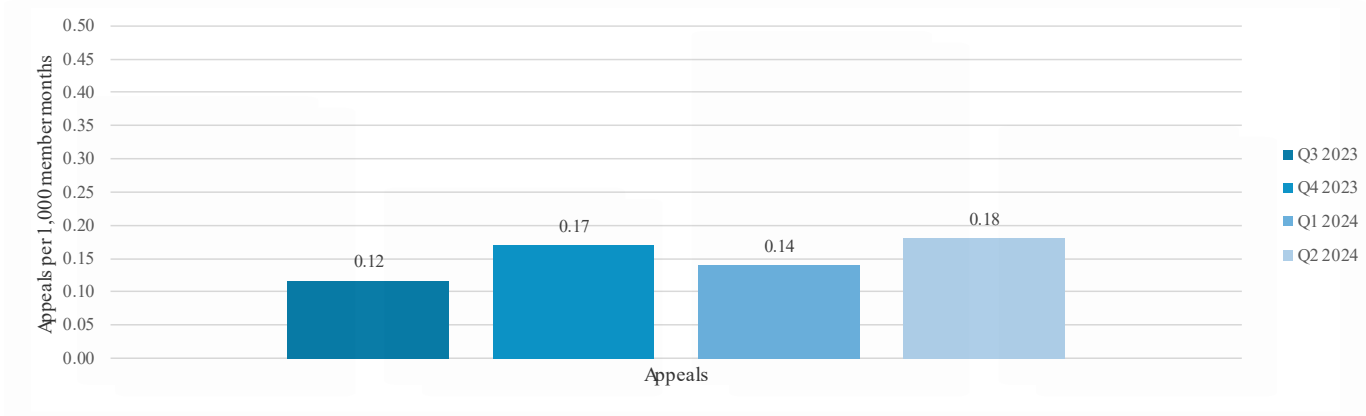
Appeals

Appeals Volume and Compliance

Timeframe	Total Appeals
Q3 2023	343
Q4 2023	490
Q1 2024	391
Q2 2024	423

Appeal: A request by the member or on the member's behalf for the review of any decision to deny, modify or discontinue a covered service.



Note: Turnaround Time (TAT) Remains Compliant

Complaint Type	Required TAT	CalOptima TAT	Compliance Percentage
Appeals	30 Days	25 Days	98%

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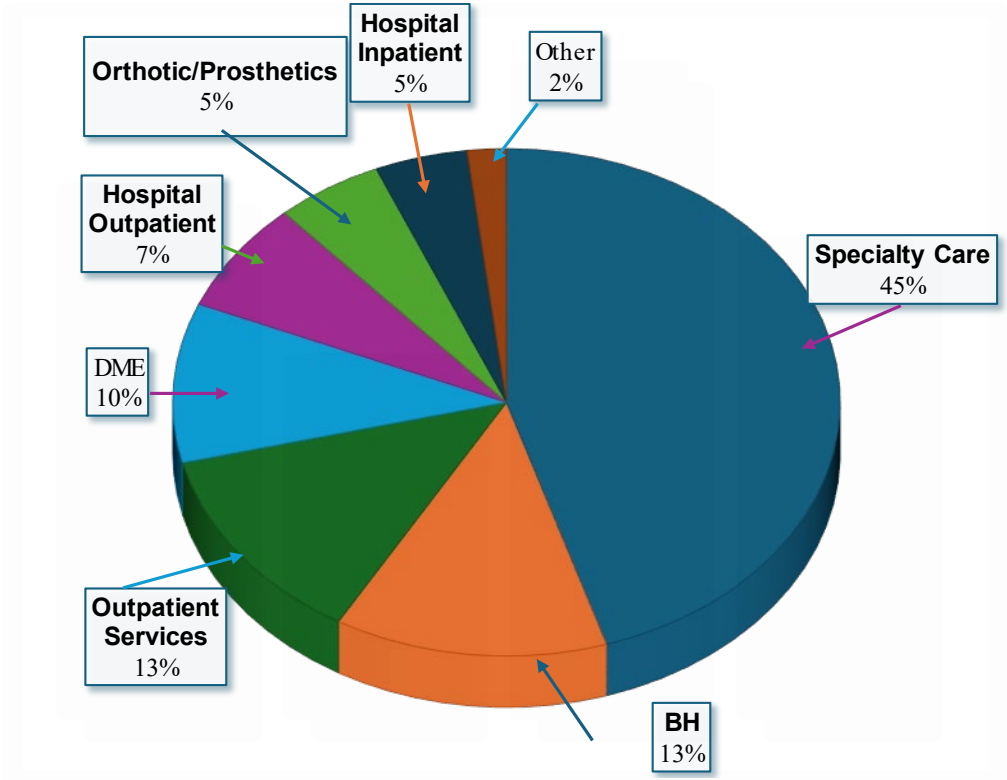
Overall Appeal Types (Medi-Cal and OneCare)

Received in Q2 2024



Type	Volume
Specialty Care	191
Behavioral Health (BH)	56
Outpatient Services	54
DME	43
Hospital Outpatient	30
Orthotics/Prosthetics	22
Hospital Inpatient	19
Other	8

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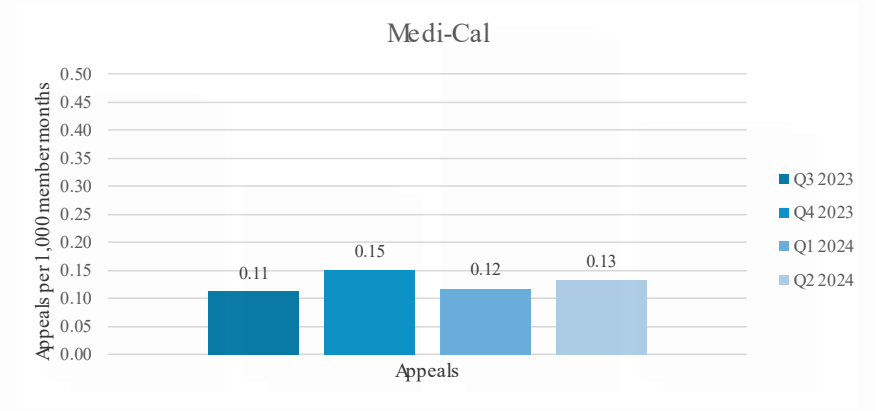
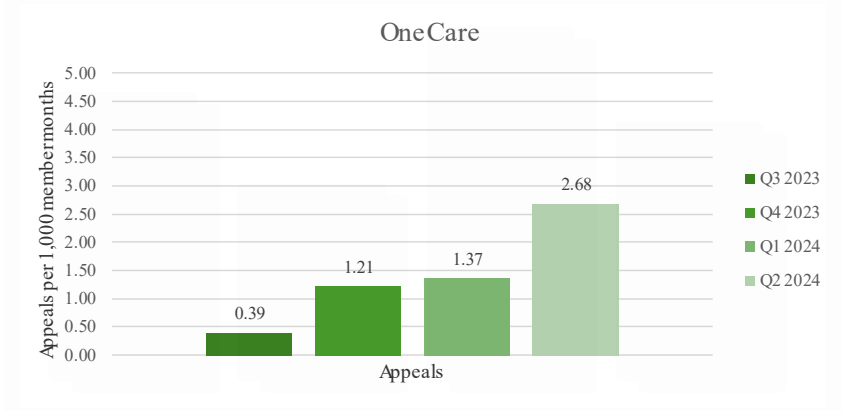
Appeals Volume by Line Of Business (LOB)



Total Appeals	
Q2 2024	356
Q1 2024	320
Q4 2023	426
Q3 2023	322



Total Appeals	
Q2 2024	67
Q1 2024	71
Q4 2023	64
Q3 2023	21

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Appeal Types by Line of Business Q2 2024

Service Types	Medi-Cal Q2 2024 (Percentage of Total Volume)	OneCare Q2 2024 (Percentage of Total Volume)
Specialty Care	45% (162)	45% (29)
Behavioral Health (BH)	16% (56)	0% (0)
Outpatient Services	12% (43)	17% (11)
DME	9% (32)	17% (11)
Hospital Outpatient	8% (27)	5% (3)
Orthotics/Prosthetics	5% (17)	8% (5)
Hospital Inpatient	5% (18)	2% (1)
Other	1% (4)	6% (4)
TOTAL	359	64

Quarter 2 Total	423

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Actions Taken

- Behavioral Health Services
  - Provider training completed to educate providers on the submission requirements for a complete review of Applied Behavior Analysis (ABA) services

- Specialty Care: Related to Tertiary Level of Care and Continuity of Care
  - Provider authorization requests were redirected to available providers who can treat the condition and have appointment availability
  - Providers are being educated on the tertiary level of care requirements
  - Optum was reminded of the requirements regarding continuity of care among the providers previously contracted under Monarch, Talbert and Arta

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CHAMBER HILL

MEMORANDUM

TO:	CalOptima Health Board of Directors
FROM:	Chamber Hill Strategies
DATE:	November 22, 2024
SUBJECT:	December Board of Directors Report

Chamber Hill Strategies Continues Outreach to Congressional Offices

In November, Chamber Hill Strategies continued to be in contact with congressional offices representing CalOptima Health's members and Orange County in Congress. In its communications with offices, Chamber Hill Strategies highlighted CalOptima Health investments in Orange County, including providing mental health services in Orange County schools, the announcement of recipients of CalOptima Health's behavioral health workforce grants, and the grand opening of the Estrella Springs development in Santa Ana. Offices contacted included Senator Laphonza Butler (D-CA), Senator Alex Padilla (D-CA), Representative Lou Correa (D-CA-46), Representative Young Kim (R-CA-40), Representative Michelle Steel (R-CA-45), Representative Katie Porter (D-CA-47), Representative Linda Sanchez (D-CA-38), and Representative Mike Levin (D-CA-49).

Trump Announces Health Picks for HHS and CMS

Following the November 5th election, President-Elect Donald Trump has moved quickly to fill his cabinet and name who will serve as top officials in the next Trump Administration, including announcing his intended nominations of Robert F. Kennedy, Jr. to the role of Secretary of Health & Human Services and Mehmet Oz, MD to serve as Administrator of the Centers for Medicare & Medicaid Services (CMS). The formal confirmation process cannot move forward until the new Congress is sworn into office in January, but much of the background work will be undertaken by congressional leaders and staff in the coming weeks. The nominations together offer some clues of how health care policy might be carried out in a second Trump Administration, but questions remain as neither Kennedy nor Oz have previously worked in a formal public policymaking role.

During the 2024 presidential campaign, and with his endorsement of Donald Trump, Robert F. Kennedy Jr. outlined a platform aimed at reshaping the nation's health policies under the banner of "Make America Healthy Again." RFK Jr.'s approach to healthcare is rooted in his longstanding commitment to environmental activism, public health advocacy, and a skepticism of the pharmaceutical industry. While there will be competing priorities, it is expected that Republican majorities in Congress will move to implement much of the Trump health policy agenda, which is expected to include a significant portion of RFK Jr.'s "Make America Healthy Again" plan. With the dual nominations of Kennedy and Oz, one can start to see two potentially distinct roles, with Kennedy focusing much of his efforts on his "Make America Healthy Again" plan for healthy food, public health and wellness, and Oz serving in the role of partnering closely with the new Department of Government Efficiency (DOGE) to eliminate waste within the agency and to reign in fraud in Medicare and Medicaid. In past remarks, Oz has expressed strong support for what he called "Medicare Advantage for All" or privatized Medicare, saying he wanted to increase access to private plans in Medicare. There is scant information about Oz's positions on Medicaid and access to coverage, but he has made statements supporting safety-net care in

the past, has supported access to short-term health plans, and has floated the idea of expanding access to Medicare Advantage. Should Congress consider Medicaid changes next year, Oz would be expected to be the Administration's leading voice in these efforts. Through this process, Oz, along with Republicans in Congress, could move to change funding, pose limitations related to immigration status, and add work requirements.

Congressional Outlook for Government Funding and Health Legislation

As of this writing, Congress has yet to reach an agreement on appropriations bills to fully fund the government for Fiscal Year 2025 (FY2025) past December 20, 2024. All eyes are on House Republican leadership for signs of what next steps might be. While House Majority Leader Steve Scalise (R-LA) has expressed a preference for funding the government through FY2025 (i.e. September 30, 2025), Speaker of the House Mike Johnson (R-LA) seems to be leaning toward a shorter term funding bill that would extend funding for government programs through early 2025 (e.g. March 31), tasking the new Congress and Administration with reaching an agreement on remaining FY2025 government funding in the new year. Before the end of the year, Congress also needs to address several expiring health provisions, which include telehealth flexibility and funding for community health centers among several others. While Congress is expected to extend and fund these expiring health programs past December, it remains an open question if Congress will extend these programs through all of FY2025. Should Congress only pass a short-term funding bill into early 2025, it is expected that will similarly only extend these programs through early 2025 as well.

Regulatory Outlook – Rules on the Horizon for November and December

CMS recently released several final rules outlining Medicare payments for physicians, home health, and hospital outpatient prospective payments in 2025. Next up, CMS is expected to release the proposed rule on Medicare Advantage and Part D rates in the coming weeks—if not sooner.

MACPAC Holds October Meeting

On October 31 and November 1, 2024, the Medicaid and CHIP Payment and Access Commission (MACPAC) met for its October 2024 meeting. Topics discussed included medication coverage for opioid use disorder (MOUD), provisional plans of care, multi-year continuous eligibility for children, external quality review for managed care plans, transitions of care for youth with special health care needs and directed payments in Medicaid managed care.

During the discussion of medication coverage for opioid use disorder (MOUD), staff noted that while MOUD is required of all states, there are gaps in care. Availability is limited due to low reimbursement, the cost of administering care to persons with opioid use disorder, and conflicting state, federal, and medical regulations. Commissioners requested staff do further analysis. The discussion of timely access to home and community-based services (HCBS) specifically focused on provisional plans of care. Since 2000, CMS has had a policy in place that allows states to cover newly enrolled beneficiaries using a provisional plan of care. Staff outlined their work with interviews and analyses that show that while this policy has been in place since 2000, it is not in use in many states. Commissioner discussion centered around clarifying questions. A chapter on the issue will be included in the 2025 March MACPAC Report to Congress. MACPAC also heard from a panel on multi-year continuous eligibility (CE) for children. Staff provided background on the new 12-month continuous eligibility (CE) mandate, which states are looking to provide CE for children, and barriers to expansion. Commissioner questions focused on barriers to rolling out CE, interest in additional research on long-term outcomes, and how to partner with Medicaid plans on CE. MACPAC staff will be doing additional research on these questions and presenting them at future meetings.

On the second day, MACPAC staff presented analysis of the managed care external quality review process (EQR) and identified multiple limitations in the EQR process. To address these shortcomings, MACPAC staff presented and offered three policy options, including requiring outcomes data to be included in states' reports, standardizing EQR reporting across states, and posting state reports on Medicaid.gov. Commissioners were supportive of the options presented but also expressed support for incorporating input from stakeholders as well. In discussing transitions of care for children and youth with special health care needs (CYSHCN), it was noted that there is no federal Medicaid requirement that states provide CYSHCN with transitions of care

services as they grow into adulthood—though some states do include transition policies in their HCBS Section 1915(c) waivers and managed care organization contracts. There was general agreement among commissioners that there is a need for improved federal policy on transitions of care. Suggestions included mandating that Medicaid plans cover and support transition of care services and aligning Medicaid with ACA requirements allowing coverage under a parent's plan until age 26. Taking commissioner comments into consideration, MACPAC staff plan to return with policy recommendations at MACPAC's December meeting. In the final session, MACPAC staff reviewed and provided an update on work on directed payments in Medicaid managed care. MACPAC staff reviewed changes made in the 2024 managed care rule and examined the use of directed payments between February 1, 2023, and August 1, 2024. MACPAC staff found it is difficult to identify a relationship between additional directed payments and efforts to improve access to care. During the commissioners' discussion, it was noted that these payments have been helpful in increasing Medicaid provider rates—and thereby access—in some states, but there was also consensus that more transparency is needed to better understand directed payments and how they are being utilized to improve access to care. While no policy recommendations are forthcoming at this time, MACPAC staff will continue to monitor and report back.

MedPAC Holds November Meeting

On November 7 and 8, 2024, the Medicare Payment Advisory Commission (MedPAC) met for its November 2024 public meeting. Among the sessions of interest were a discussion on Medicare's prescription drug benefit and a presentation regarding the Commission's workplan to examine and better understand Medicare Advantage (MA) provider networks.

In considering Medicare's prescription drug benefit, the discussion examined the differences between stand-alone prescription drug plans (PDPs) for fee-for-service (FFS) beneficiaries and the Medicare Advantage–Prescription Drug Plans (MA–PDs) for beneficiaries who choose to enroll in Medicare Advantage (MA). The discussion covered the continuing shift among beneficiaries from stand-alone PDPs to MA-PDs. Among the differences, it was noted that MA-PDs tend to have lower premiums while PDPs have higher average gross costs and lower risk scores than MA-PDs. It was also noted that MA-PDs can segment the market by enrollees' Low-Income Subsidy (LIS) status using Dual Eligible Special Needs Plans (D-SNPs) and design their formularies accordingly (which PDPs cannot do). In addition, it was noted that MA plans can document additional beneficiary diagnoses which can contribute to higher Part D risk scores. This is the beginning of the Commission's work on the topic and more will follow in the future.

The presentation regarding MA provider networks reviewed MA network adequacy requirements and the challenges that the ability to initiate or terminate contracts at any time can pose to beneficiaries and network adequacy. Staff noted that while MA networks are generally broader than other markets, there is also variation based on geography and specialty. In their presentation, it was noted that narrow networks may have a disproportionately negative impact on dual eligibles and beneficiaries with chronic illnesses, such as end stage renal disease, behavioral health issues, and cancer. Staff concluded the presentation by outlining the plan for future work in greater detail, noting the goals of better understanding provider participation in MA networks, the use of networks by MA enrollees, and the impact of network adequacy standards on beneficiaries' access to care.

CALOPTIMA HEALTH - STATE LEGISLATIVE REPORT
November 24, 2024

General Update

The 120-seat California legislature will likely see 35 new legislators filling vacant seats (23 in the Assembly and 12 in the Senate, with Senator Josh Newman (D) likely losing his seat as of latest counts). Republicans are on track to gain two seats in the Assembly and one in the Senate this election cycle. The 80 Assembly seats will be divided between 60 Democrats and 19 Republicans with one vacancy, which will be filled by a Special Election early next year. The 40 State Senate seats will be comprised of roughly the same three-to-one split: 30 Democrats and 10 Republicans. The legislature will convene on December 2 to swear-in new legislators and begin their two-year legislative session. Committee assignments are also expected to be announced in the next month.

On November 7, Governor Gavin Newsom issued a proclamation to convene a Special Session of the legislature to "safeguard California values and fundamental rights in the face of an incoming Trump administration." Thus far, the Governor's focus seems to be on bolstering the financial resources of the Attorney General (up to $100 million) to immediately fund litigation against unlawful actions. Special Session will convene on December 2 when the new legislature is sworn in. However, it is unlikely they will be prepared to act immediately. The Special Session can implement urgency rules to take immediate action with a 2/3 majority vote. More details on the timing and substance of the Special Session are expected to emerge in the coming days.

Budget Update

On November 20, the Legislative Analyst's Office (LAO), the non-partisan fiscal and policy advisor to the California legislature, released their annual Fiscal Outlook for fiscal year (FY) 2025-26. While opining that the FY 2025-26 budget is "roughly balanced," LAO says the State is facing annual operating deficits of $20 billion in FY 2026-27, and $30 billion in FY 2027-28, in part due to significantly faster spending growth related to Medi-Cal. The common theme: there is no capacity for new commitments, particularly ones with ongoing funding.

According to the LAO, there are three key issues creating uncertainty in Medi-Cal spending growth in the coming years, including:

Senior Medi-Cal Caseload Surge – Medi-Cal eligibility, in addition to income limits, has traditionally required assets to be limited to $2,000 per person or $3,000 per couple. The 2021 budget package increased asset limits for seniors and then *fully eliminated* the asset limit test effective January 1, 2024. This has seemed to be a key driver in a significant senior caseload surge in six months (from 1,600 in January 2024 to 14,500 in July 2024).

Health Care Worker Minimum Wage Increases – The Health Care Minimum Wage became effective in October 2024. Because of the complexity of the law, establishing five different minimum wage schedules, the impact on the budget is uncertain. The Department of Finance (DOF) has stated the General Fund cost will be in the low billions of dollars annually while others have estimated the cost to

be in the low hundreds of millions of dollars. These dollars are mostly attributable to Medi-Cal and are difficult to quantify at this point.

Managed Care Organization (MCO) Tax – In recent years, the General Fund has been backfilled by leveraging federal reimbursement dollars with the MCO Tax, allowing flexibility by the legislature and Governor to balance the budget. MCO Tax revenue to offset Medi-Cal has become more complex and uncertain because of:

- *Pending Federal Approval of Current MCO Tax Increases* – The current version of the MCO tax was approved in December 2023. Federal approval is pending on additional tax increases enacted as part of the FY 2024-25 budget. This approval is expected in December 2024.

- *Effects of Proposition 35 (MCO Tax) Passage* – The General Fund is expected to have increased costs (estimated $2-3 billion) since Proposition 35 requires the state to use more money for Medi-Cal, allowing less flexibility for the legislature and Governor to backfill other programs. In addition, Proposition 35 outlines different funding priorities than those outlined by the legislature and Governor in the current MCO Tax. That means the legislature may want to reconsider programs they currently fund that are no longer supported in Propositio 35.

- *Federal Rule Changes May Decrease Funds* – Federal officials have previously indicated they plan to restructure health care-related taxes, including the MCO Tax. It is unclear when or how these changes will evolve and how the MCO Tax or other Medi-Cal funding would be impacted.

Propositions and Initiatives

Proposition 35 (MCO Tax) – Voters approved Proposition 35 to permanently fund Medi-Cal in the November 2024 election. Proposition 35 won by a wide margin of 68%, 5% higher than polls had suggested. The measure makes the MCO tax on health plans permanent under state law and specifies how the funds are to be used, meaning less flexibility for the legislature and Governor to use the money for other priorities. The DOF estimates it will amount to a $12 billion decrease in funds that the state had planned to balance the budget through 2027.

Proposition 1 (Behavioral Health Transformation) – The request for applications for Round 1 of bond funding ($3.3 billion) was released in July and applications are due in December. Counties, cities, tribes, non-profits, and for-profits are eligible to apply. DHCS prioritizes collaborative partnerships and campus-type models. County mental health departments must support the proposed projects, and matching funds/collateral are required by the proposer.

2023–24 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
S. 3430 Wyden (OR) Crapo (ID)	**Better Mental Health Care, Lower-Cost Drugs, and Extenders Act:** Would expand access to behavioral health services, reduce prescription drugs costs through pharmacy benefit manager (PBM) reforms and extend certain expiring provisions of the Medicare and Medicaid programs. Specific notable elements include but are not limited to the following: • Increasing all Medicare physician fee schedule payments by 2.5% (rather than 1.25%) for 2024 services. • Increasing Medicare physician fee schedule payments for certain behavioral health integration services in primary care settings during 2026–28. • Increasing Medicare bonus payments to providers that furnish mental health and substance use disorder (SUD) services in health professional shortage areas; expanding such bonus payments to include non-physician health care professionals. • Expanding access to behavioral telehealth services across state lines and for those with limited English proficiency. • Medicaid funding of up to seven days for services delivered to incarcerated individuals diagnosed with an SUD and pending disposition of charges. • Eliminating cuts to Medicaid disproportionate share hospital payments through September 30, 2025. Additionally, would include provisions from S. 3059, the Requiring Enhanced & Accurate Lists of (REAL) Health Providers Act, to require accurate provider directories on public websites updated every 90 days. ***Potential CalOptima Health Impact:*** Increased access to behavioral health services for CalOptima Health members; increased funding for contracted providers; increased staff oversight of CalOptima Health's OneCare provider directory.	**12/07/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
S. 923 Bennet (CO)	**Better Mental Health Care for Americans Act:** Would require parity for mental health services in Medicaid, Medicare Advantage (MA) and Medicare Part D. Would also enhance Medicaid and Medicare payments for integrating mental health and SUD services with physical care. Finally, would create a 54-month Medicaid demonstration project to increase state funding for enhanced access to mental health services for children. In addition, would require MA plans to verify and update provider directories at least every 90 days and remove a non-participating provider within two business days of notification. ***Potential CalOptima Health Impact**:* Increased access to behavioral health services for CalOptima Health members; increased funding for contracted providers; increased staff oversight of OneCare provider directory.	**03/22/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
S. 1378 Cortez Masto (NV)	**Connecting Our Medical Providers with Links to Expand Tailored and Effective (COMPLETE) Care Act:** Would improve access to timely, effective mental health care in the primary care setting by increasing Medicare payments to providers for implementing integrated care models. ***Potential CalOptima Health Impact**:* Increased resources and access to behavioral health services for CalOptima Health OneCare members; increased funding for contracted providers.	**04/27/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
SB 363 Eggman	**Behavioral Health Facilities Database:** No later than January 1, 2026, would require the California Department of Health Care Services (DHCS) to develop a real-time, internet-based database to display information about beds in certain facilities, including chemical dependency recovery hospitals, acute psychiatric hospitals and mental health rehabilitation centers, to identify the availability of inpatient and residential mental health or SUD treatment. ***Potential CalOptima Health Impact:*** Increased resources and access to behavioral health services for CalOptima Health Medi-Cal members.	**08/16/2024** Died in Assembly Appropriations Committee **06/13/2023** Passed Assembly Health Committee **05/24/2023** Passed Senate floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 492 Pellerin	**Reproductive and Behavioral Health Integration Pilot Programs:** Would provide grants, incentive payments or other financial support to Medi-Cal managed care plans (MCPs) to partner with providers for the development and implementation of behavioral health integration pilot programs to improve access to services. Partnering providers must be enrolled in the Family Planning, Access, Care, and Treatment (Family PACT) program and provide reproductive health services. ***Potential CalOptima Health Impact*:** Increased funding and access to reproductive and behavioral health services.	**07/03/2024** Died in Senate Health Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch
AB 512 Waldron	**Behavioral Health Facilities Database:** Would require the California Health and Human Services Agency (CalHHS) to create a committee to study how to develop a real-time, internet-based system, usable by hospitals, clinics, law enforcement, paramedics and emergency medical technicians, and other health care providers to display information about available beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities and residential alcoholism or substance abuse treatment facilities in order to identify available facilities for the temporary treatment of individuals experiencing a mental health or SUD crisis. ***Potential CalOptima Health Impact*:** Increased efficiency and timeliness of facility referrals; decreased visits to the emergency department.	**01/19/2024** Died in Assembly Appropriations Committee **03/14/2023** Passed Assembly Health Committee	CalOptima Health: Watch
AB 940 Villapudua	**Eating Disorder Treatment:** Would expand the approved facilities for inpatient treatment of eating disorders to include psychiatric health facilities. ***Potential CalOptima Health Impact*:** Increased access to treatment for eating disorders.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1316 Irwin	**Psychiatric Emergency Medical Conditions:** Would require the Medi-Cal program to cover emergency services and care necessary to treat a psychiatric emergency medical condition, including post-stabilization care services, emergency room professional services, and facility charges for emergency room visits — regardless of whether the beneficiary was voluntarily or involuntarily admitted. ***Potential CalOptima Health Impact*:** Increased scope of behavioral health services for CalOptima Health Medi-Cal members.	**09/27/2024** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1470 Quirk-Silva	**Behavioral Health Documentation Standards:** Would require DHCS to standardize data elements relating to documentation requirements, including medically necessary criteria and develop standard forms containing information necessary to properly adjudicate claims. No later than July 1, 2025, regional personnel training on documentation should be completed along with the exclusive use of the standard forms. ***Potential CalOptima Health Impact*:** New data requirements; additional training for CalOptima Health behavioral health staff on new documentation.	**09/14/2024** Vetoed *(see **veto message**)*	CalOptima Health: Watch
AB 1936 Cervantes	**Maternal Mental Health Screenings:** Would require a health plan's maternal mental health program to consist of at least one maternal mental health screening during pregnancy, at least one additional screening during the first six weeks of the postpartum period, and additional postpartum screenings, if determined medically necessary and clinically appropriate, to improve treatment and referrals to other maternal mental health services, including coverage for doulas. ***Potential CalOptima Health Impact:*** Expanded Medi-Cal benefit for CalOptima Health Medi-Cal members.	**09/28/2024** Signed into law	CalOptima Health: Watch
Budget			
H.R. 2872 Graves (LA)	**Further Additional Continuing Appropriations and Other Extensions Act, 2024:** Enacts a third Continuing Resolution (CR) to further extend Fiscal Year (FY) 2023 federal spending levels from January 19, 2024, through March 1, 2024, for certain agencies, and from February 2, 2024, through March 8, 2024, for other agencies. ***Potential CalOptima Health Impact:*** Continuation of current federal spending on programs impacting CalOptima Health members.	**01/19/2024** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 2882 Ciscomani (AZ)	**Further Consolidated Appropriations Act, 2024:** Enacts the remaining six FY 2024 appropriations bills, as follows, to fund several federal departments and agencies in the amount of $1.2 trillion through September 30, 2024: • Department of Defense Appropriations Act, 2024 • Financial Services and General Government Appropriations Act, 2024 • Department of Homeland Security Appropriations Act, 2024 • Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2024 • Legislative Branch Appropriations Act, 2024 • Department of State, Foreign Operations, and Related Programs Appropriations Act, 2024 Of note, funding for the U.S. Department of Health and Human Services (HHS) remains relatively flat with only a 1% increase compared to FY 2023. However, approximately $4.3 billion in unspent COVID-19 relief funding is rescinded. ***Potential CalOptima Health Impact:*** Adjusted but broadly sustained funding for federal programs impacting CalOptima Health members.	**03/23/2024** Signed into law	CalOptima Health: Watch
H.R. 4366 Carter (TX)	**Consolidated Appropriations Act, 2024:** Enacts six of the 12 regular FY 2024 appropriations bills, as follows, to fund several federal departments and agencies in the amount of $459 billion through September 30, 2024: • Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2024 • Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 2024 • Commerce, Justice, Science, and Related Agencies Appropriations Act, 2024 • Energy and Water Development and Related Agencies Appropriations Act, 2024 • Department of the Interior, Environment, and Related Agencies Appropriations Act, 2024 • Transportation, Housing and Urban Development, and Related Agencies Appropriations Act, 2024 In addition, extends several expiring programs and authorities, including several public health programs. ***Potential CalOptima Health Impact:*** Adjusted but broadly sustained funding for federal programs impacting CalOptima Health members.	**03/09/2024** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 7463 Granger (TX)	**Extension of Continuing Appropriations and Other Matters Act, 2024:** Enacts a fourth CR to further extend FY 2023 federal spending levels from March 1, 2024, through March 8, 2024, for federal agencies through March 8, 2024, and through March 22, 2024, for other agencies. ***Potential CalOptima Health Impact:*** Continuation of current federal spending on programs impacting CalOptima Health members.	**03/01/2024** Signed into law	CalOptima Health: Watch
SB 136 Committee on Budget and Fiscal Review	**Managed Care Organization (MCO) Provider Tax Amendment Trailer Bill I:** Subject to approval by the Centers for Medicare and Medicaid Services (CMS), increases the Medi-Cal per enrollee tax amount on health plans in Medi-Cal taxing tier II to $205 during the 2024, 2025 and 2026 calendar years. ***Potential CalOptima Health Impact:*** Increased tax liability on CalOptima Health to be reimbursed at an approximately equivalent amount; increased funding for Medi-Cal programs and provider rates.	**03/25/2024** Signed into law	CalOptima Health: Watch
SB 159 Committee on Budget and Fiscal Review	**Health Trailer Bill:** Consolidates and enacts certain budget trailer bill language containing the policy changes needed to implement health-related expenditures in the FY 2024-25 state budget. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed analysis of the FY 2024–25 Enacted State Budget.	**06/29/2024** Signed into law	CalOptima Health: Watch
AB 106 Gabriel	**Budget Acts of 2022 and 2023:** Amends the Budget Act of 2022 and the Budget Act of 2023 to support appropriations for FYs 2023–24 as part of the early action agreement that includes a combination of $3.6 billion in reductions (primarily to one-time funding), $5.2 billion in revenue and borrowing, $5.2 billion in delays and deferrals, and $3.4 billion in shifts of costs from the General Fund to other state funds. Significant health care provisions include the following: • Behavioral Health Continuum Infrastructure Program: $140.4 million delay • Behavioral Health Bridge Housing: $235 million delay • MCO Provider Tax: $3.8 billion in revenue borrowing ***Potential CalOptima Health Impact*:** Adjusted but broadly sustained funding for behavioral health programs impacting CalOptima Health members.	**04/03/2024** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 107 Gabriel **SB 108** Wiener	**Budget Act of 2024:** Makes appropriations for the government of the State of California for FY 2024–25. Total spending is $293 billion, of which $211.5 billion is from the General Fund. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed analysis of the FY 2024–25 Enacted State Budget.	**06/29/2024** Signed into law	CalOptima Health: Watch
AB 160 Committee on Budget	**MCO Provider Tax Amendment Trailer Bill II:** Subject to approval by CMS, further increases the Medi-Cal per enrollee tax amount on health plans in Medi-Cal taxing tier II from $205 to $274 during the 2024, 2025 and 2026 calendar years. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed analysis of the FY 2024–25 Enacted State Budget.	**06/29/2024** Signed into law	CalOptima Health: Watch
California Advancing and Innovating Medi-Cal (CalAIM)			
AB 586 Calderon	**Community Support: Climate Change or Environmental Remediation Devices:** Would add "climate change or environmental remediation devices" as a Medi-Cal Community Support option, defined as the coverage and installation of devices to address health-related complications, barriers or other factors linked to extreme weather, poor air quality or other climate events, including air conditioners, electric heaters, air filters and backup power sources. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members to address social determinants of health (SDOH).	**01/19/2024** Died in Assembly Appropriations Committee **04/11/2023** Passed Assembly Health Committee	CalOptima Health: Watch
AB 1338 Petrie-Norris	**Community Support: Fitness**: Would add fitness, physical activity, or recreational sports programs, activities, or memberships as a Medi-Cal Community Support option. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members to address SDOH.	**01/19/2024** Died in Assembly Appropriations Committee **04/18/2023** Passed Assembly Health Committee	CalOptima Health: Watch
Covered Benefits			
SB 324 Limón	**Endometriosis:** Would add any clinically indicated treatment for endometriosis as a covered benefit without prior authorization or other utilization review. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**08/16/2024** Died in Assembly Appropriations Committee **06/27/2023** Passed Assembly Health Committee **05/24/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 339 Wiener	**Human Immunodeficiency Virus (HIV) Preexposure Prophylaxis (PrEP) and Postexposure Prophylaxis (PEP):** Increases Medi-Cal coverage of PrEP and PEP furnished by a *pharmacist* from a 60-day maximum course to a 90-day maximum course, which could be further extended under certain conditions. ***Potential CalOptima Health Impact:*** Expanded Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**02/06/2024** Signed into law	CalOptima Health: Watch CAHP: Oppose
SB 953 Menjivar	**Menstrual Products:** Would add menstrual products as covered Medi-Cal benefits. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**05/17/2024** Died in Senate Appropriations Committee **03/20/2024** Passed Senate Health Committee	CalOptima Health: Watch
SB 1180 Ashby	**Emergency Medical Services:** Would add services provided by a community paramedicine program, triage to alternate destination program, or mobile integrated health program as covered Medi-Cal benefits, subject to an appropriation by the Legislature. ***Potential CalOptima Health Impact:*** Expanded covered benefits for CalOptima Health Medi-Cal members.	**09/28/2024** Signed into law	CalOptima Health: Watch
AB 47 Boerner	**Pelvic Floor Physical Therapy**: Beginning January 1, 2024, would require health plans to provide coverage for pelvic floor physical therapy after pregnancy. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 365 Aguiar-Curry	**Continuous Glucose Monitors (CGMs):** Would add CGMs and related supplies as a covered Medi-Cal benefit for the treatment of diabetes when medically necessary, subject to utilization controls. Would also allow DHCS to require a manufacturer of CGMs to enter into a rebate agreement with DHCS. ***Potential CalOptima Health Impact:*** Expanded covered benefits for CalOptima Health Medi-Cal members.	**08/31/2024** Died on Senate floor **08/21/2023** Re-referred to Senate floor **06/21/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch CalPACE: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1036 Bryan	**Emergency Medical Transportation:** Would require a physician to certify upon patient arrival at an emergency room via emergency medical transportation whether an emergency medical condition existed and required emergency medical transportation. If certified, would require a health plan to provide coverage for emergency medical transportation. ***Potential CalOptima Health Impact:*** Increased CalOptima Health costs for reimbursement of emergency transportation services.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1975 (AB 1644) Bonta	**Medically Supportive Food**: No sooner than July 1, 2026, and subject to an appropriation by the Legislature, would add medically supportive food and nutrition intervention plans as covered Medi-Cal benefits, when determined to be medically necessary to a patient's medical condition by a provider or plan. The benefit would be based in part on the following Community Support offered through CalAIM: Medically Tailored Meals. ***Potential CalOptima Health Impact:*** Formalization and expansion of certain Community Support services as covered benefits for eligible CalOptima Health Medi-Cal members.	**09/25/2024** Vetoed *(see veto message)*	CalOptima Health: Watch LHPC: Support CAHP: Support
AB 2105 (AB 907) Lowenthal	**PANDAS and PANS**: Beginning January 1, 2025, would require a health plan to provide coverage for prophylaxis, diagnosis and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS), prescribed or ordered by a provider as medically necessary. ***Potential CalOptima Health Impact:*** Continued covered benefit for pediatric CalOptima Health Medi-Cal members.	**09/28/2024** Signed into law	CalOptima Health: Watch CAHP: Oppose
AB 2446 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 ***Potential CalOptima Health Impact:*** New covered benefit for pediatric CalOptima Health Medi-Cal members.	**09/27/2024** Vetoed *(see veto message)*	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2668 Berman	**Cranial Prostheses:** Beginning January 1, 2025, would add cranial prostheses as a covered Medi-Cal benefit as part of a prescribed course of treatment for individuals experiencing permanent or temporary medical hair loss. Coverage would be limited to a maximum of $750 for each instance, no more than once per year. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**05/17/2024** Died in Assembly Appropriations Committee **04/23/2024** Passed Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 2843 Petrie-Norris	**Rape and Sexual Assault Care:** Beginning July 1, 2025, would require a health plan to provide coverage without cost-sharing for emergency room medical care and follow-up treatment following a rape or sexual assault. Would also prohibit a health plan from requiring members to provide a police report or press charges for rape or sexual assault in order to receive care. ***Potential CalOptima Health Impact:*** Expanded covered benefits for CalOptima Health Medi-Cal members.	**09/29/2024** Signed into law	CalOptima Health: Watch
Medi-Cal Eligibility and Enrollment			
S. 423 Van Hollen (MD) **H.R. 1113** Bera (CA)	**Easy Enrollment in Health Care Act:** To streamline and increase enrollment into public health insurance programs, would allow taxpayers to request their federal income tax returns include a determination of eligibility for Medicaid, the Children's Health Insurance Program (CHIP) or advance premium tax credits to purchase insurance through a health plan exchange. Taxpayers could also consent to be automatically enrolled into any such program or plan if they were subject to a zero net premium. Would also make individuals eligible for Medicaid or CHIP based on a prior finding of eligibility for the Temporary Assistance for Needy Families program or the Supplemental Nutrition Assistance Program. ***Potential CalOptima Health Impact*:** Expanded eligibility standards and procedures for enrollment of CalOptima Health members.	**02/14/2023** Introduced; referred to committees	CalOptima Health: Watch
H.R. 8084 Bilirakis (FL)	**LIVE Beneficiaries Act:** Beginning January 1, 2026, would require states to verify the Medicaid eligibility of current enrollees by checking the Social Security Death Master File quarterly to ensure deceased individuals are no longer enrolled in Medicaid. ***Potential CalOptima Health Impact:*** Improved accuracy of member data files from DHCS.	**09/17/2024** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 8111 Miller-Meeks (IA)	**Medicaid Program Improvement Act:** Beginning January 1, 2026, would require Medicaid programs to implement a process to obtain updated addresses for enrollees. Would also require all Medicaid MCPs to report addresses that are directly verified by enrollees to the state. ***Potential CalOptima Health Impact:*** Additional transmission of member data to DHCS.	**09/17/2024** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch
SB 1289 Roth	**Medi-Cal Call Center Data:** Beginning on January 1, 2026, would require county Medi-Cal call centers to collect and submit monthly data metrics to DHCS. Beginning on May 15, 2026, would require DHCS to prepare a publish online a quarterly report on submitted call center. ***Potential CalOptima Health Impact:*** Increased resources for CalOptima Health members; increased number of CalOptima Health members as a result of additional new enrollments and fewer disenrollments.	**09/27/2024** Signed into law	CalOptima Health: Watch
AB 1608 Patterson	**Regional Center Clients:** Would exempt from mandatory Medi-Cal MCP enrollment any dual-eligible and non-dual-eligible Medi-Cal beneficiaries who receive services from a regional center and use the Medi-Cal fee-for-service (FFS) delivery system as secondary form of health coverage. ***Potential CalOptima Health Impact:*** Decreased number of CalOptima Health members.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1783 Essayli	**Unsatisfactory Immigration Status:** States the intent of the Legislature to enact legislation to prohibit state funding of health care benefits for individuals with unsatisfactory immigration status. ***Potential CalOptima Health Impact:*** Decreased number of CalOptima Health members	**05/03/2024** Died without referral to committee	CalOptima Health: Watch
AB 2956 Boerner	**Adult Continuous Eligibility and Redetermination:** Would require DHCS to seek federal approval to extend continuous Medi-Cal eligibility to individuals over 19 years of age. Would also require a county to attempt communication through all additional available channels before completing a redetermination and to conduct an additional review of information in an attempt to renew eligibility without needing a response., Would require counties to accept self-attested information from beneficiary for the purpose of income verification during a redetermination. ***Potential CalOptima Health Impact*:** Expanded eligibility standards and procedures for enrollment and re-enrollment of CalOptima Health members.	**05/17/2024** Died in Assembly Appropriations Committee **04/16/2024** Passed Assembly Health Committee	CalOptima Health: Watch LHPC: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Operations and Administration			
H.R. 2811 Arrington (TX)	**Limit, Save, Grow Act of 2023:** Would require Medicaid beneficiaries ages 19–55 without dependents to work, complete community service and/or participate in a work training program for at least 80 hours per month for at least three months per year. Exemptions would be provided for those who are pregnant, physically or mentally unfit for employment, complying with work requirements under a different federal program, participating in a drug or alcohol treatment program, or enrolled in school at least half-time. HHS estimates that 294,981 Medi-Cal beneficiaries in Orange County would be subject to the proposed work requirements without an exemption. ***Potential CalOptima Health Impact:*** Disenrollment of certain CalOptima Health Medi-Cal members, especially those who experience homelessness, who are not exempt from work requirements.	**04/26/2023** Passed House floor; referred to Senate Budget Committee	CalOptima Health: Concerns ACAP: Oppose
SB 1120 Becker	**Artificial Intelligence (AI) in Utilization Review:** Would require a health plan's use of algorithms, AI, and other software tools for utilization management (UM) purposes to comply with specified fairness and equity requirements and to be based on individual clinical history and circumstances. ***Potential CalOptima Health Impact:*** Implementation of new UM procedures.	**09/28/2024** Signed into law	CalOptima Health: Watch
AB 1690 Kalra	**Universal Health Care Coverage**: States the intent of the Legislature to guarantee accessible, affordable, equitable and high-quality health care for all Californians through a comprehensive universal single-payer health care program. ***Potential CalOptima Health Impact:*** Unknown but potentially significant impacts to the Medi-Cal and commercial health care delivery systems, including changes to administration, covered benefits, financing and organization.	**01/19/2024** Died without referral to committee	CalOptima Health: Watch
AB 2200 Kalra	**Guaranteed Health Care for All:** Would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of California. ***Potential CalOptima Health Impact:*** Unknown but potentially significant impacts to the Medi-Cal and commercial health care delivery systems, including changes to administration, covered benefits, financing and organization.	**05/17/2024** Died in Assembly Appropriations Committee **04/23/2024** Passed Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2340 Bonta	**EPSDT Informational Materials:** Would require DHCS to standardize informational materials that effectively explain and clarify the scope and nature of EPSDT services that are available under the Medi-Cal program, including content designed for youth. Would require a Medi-Cal MCP to provide the informational materials to EPSDT-eligible beneficiaries and their parents within a certain period (as determined by DHCS) of initial enrollment into the MCP and annually thereafter. ***Potential CalOptima Health Impact:*** Standardization and increased number of mailings to certain CalOptima Health Medi-Cal members.	**09/25/2024** Signed into law	CalOptima Health: Watch
AB 2466 Carrillo	**Network Adequacy Standards:** Would deem a Medi-Cal MCP out of compliance with appointment time standards if either of the following are true: • Fewer than 85% of network providers had an appointment available within the standards • DHCS receives information establishing that the plan was unable to deliver timely, available or accessible health care services Would also require health plans to submit an annual renewal request for alternative access standards, describing the efforts made in the previous 12 months to mitigate or eliminate circumstances that justify the use of an alternative access standard. ***Potential CalOptima Health Impact:*** Increased network analysis and reporting to DHCS.	**05/17/2024** Died in Assembly Appropriations Committee **04/16/2024** Passed Assembly Health Committee	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
AB 3260 Pellerin	**Utilization Reviews and Grievances:** Would require health plans to complete utilization review decisions within 72 hours. If a plan fails to meet such deadline, the plan must automatically open a grievance on behalf of the affected beneficiary. Additionally, would require plans to review urgent grievances, as determined by the provider, within 72 hours. ***Potential CalOptima Health Impact***: Expedited and modified UM and Grievance procedures for covered Medi-Cal benefits.	**08/16/2024** Died in Senate Appropriations Committee **06/26/2024** Passed Senate Health Committee **05/21/2024** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Older Adult Services			
S. 1002 Cassidy (LA)	**No Unreasonable Payments, Coding, or Diagnoses for the Elderly (No UPCODE) Act:** Would modify the MA risk adjustment model to prevent overpayment to MA plans, as follows: • Utilization of two years instead of one of diagnostic data • Exclusion of outdated diagnoses solely included on health risk assessments • Coding adjustment to account for other payment differences between MA and Medicare FFS ***Potential CalOptima Health Impact:*** Decreased reimbursement rates from the CMS for CalOptima Health OneCare members.	**03/28/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
S. 1703 Carper (DE) **H.R. 3549** Wenstrup (OH)	**Program of All-Inclusive Care for the Elderly (PACE) Part D Choice Act of 2023:** Would allow a Medicare-only PACE participant to opt out of drug coverage provided by the PACE program and instead enroll in a standalone Medicare Part D prescription drug plan that results in equal or lesser out-of-pocket costs. PACE programs would be required to educate their participants about this option. ***Potential CalOptima Health Impact:*** Increased enrollment into CalOptima Health PACE by Medicare-only beneficiaries due to decreased out-of-pocket costs.	**05/18/2023** Introduced; referred to committees	**08/30/2023** CalOptima Health: SUPPORT NPA: Support
S. 3950 Cassidy (LA)	**Delivering Unified Access to Lifesaving Services (DUALS) Act of 2024:** Would require each state to develop and implement a comprehensive, integrated health plan for beneficiaries dually eligible for Medicaid and Medicare. Would also expand PACE coverage nationwide to individuals under the age of 55 as well as allow PACE enrollment at any time of the month. ***Potential CalOptima Health Impact:*** Increased coordination and benefits for dually eligible CalOptima Health members; increased enrollment into CalOptima Health PACE.	**03/14/2024** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
AB 1022 Mathis	**PACE Rates and Assessments**: Would require PACE capitation rates to also reflect the frailty level and risk associated with participants. In addition, would expand a PACE organization's authority to use video telehealth to conduct all assessments. ***Potential CalOptima Health Impact:*** Increased capitation rates for CalOptima Health PACE participants; expanded use of video telehealth assessments.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1223 Hoover	**PACE Audits:** Would require DHCS to perform program audits of PACE organizations and to develop and maintain standards, rules and auditing protocols, including related to data collection, technical assistance, formal decisions and enforcement of non-compliance. ***Potential CalOptima Health Impact:*** Modified audit protocols for CalOptima Health PACE.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1230 Valencia	**Special Needs Plans (SNPs)**: No later than January 1, 2025, would require DHCS to offer contracts to health plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) to provide care to dual eligible beneficiaries. ***Potential CalOptima Health Impact:*** Increased number of SNPs in Orange County; decreased number of CalOptima Health OneCare members.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch LHPC: Oppose
Providers			
S. 3059 Bennet (CO)	**Requiring Enhanced & Accurate Lists of (REAL) Health Providers Act:** Effective plan year 2026, would require MA plans to update and ensure accurate provider directory information at least once every 90 days. If a plan is unable to verify such information for a specific provider, a disclaimer indicating that the information may not be up to date is required. Would also require the removal of a provider from a directory within five business days if the plan determines they are no longer participating in the network. ***Potential CalOptima Health Impact:*** Increased staff oversight of CalOptima Health's OneCare provider directory.	**10/17/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
H.R. 497 Duncan (SC)	**Freedom for Health Care Workers Act:** would repeal the rule issued by CMS on November 5, 2021, that requires health care providers participating in the Medicare and Medicaid programs to ensure staff are fully vaccinated against COVID-19**.** ***Potential CalOptima Health Impact:*** Elimination of COVID-19 vaccination mandate for CalOptima Health PACE staff and contracted providers.	**01/31/2023** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4758 Trahan (MA)	**Accelerating Kids' Access to Care Act:** Would require Medicaid programs to establish a process through which qualifying out-of-state providers may temporarily treat children without undergoing additional screening requirements. In addition, would require pass-through pricing models for covered drugs under Medicaid payment arrangements with pharmacy benefit managers. ***Potential CalOptima Health Impact:*** Improved access to care for pediatric CalOptima Health Medi-Cal members with complex medical conditions.	**09/17/2024** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch
H.R. 7149 Steel (CA)	**Equal Access to Specialty Care Everywhere (EASE) Act of 2024:** Would use existing Center for Medicare and Medicaid Innovation funds to test a virtual specialty network dedicated to providing a range of virtual modalities in partnership with primary care providers in underserved and rural communities, including Federally Qualified Health Centers (FQHCs). ***Potential CalOptima Health Impact:*** Expanded telehealth access for CalOptima Health members.	**01/30/2024** Introduced; referred to House Energy and Commerce Committee	CalOptima Health: Watch
H.R. 7858 James (MI)	**TELEMH Act of 2024:** No later than January 1, 2026, would require HHS to create a new code or billing modifier related to telehealth-delivered mental health services in Medicare. ***Potential CalOptima Health Impact:*** Continued use of telehealth by CalOptima Health OneCare members to access mental health services; modified Medicare coding and claims processing.	**09/17/2024** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch
H.R. 8089 Garcia (CA)	**Medicare and Medicaid Fraud Prevention Act of 2024:** Beginning January 1, 2027, would require states to check the Social Security Death Master File quarterly to determine whether Medicaid providers and suppliers are deceased. Would also enable the state to deactivate the National Provider Identifiers (NPIs) of deceased providers. ***Potential CalOptima Health Impact:*** Improved accuracy of provider enrollment data from DHCS.	**09/17/2024** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch
H.R. 8112 D'Esposito (NY)	**Medicaid Provider Screening Requirements:** Beginning January 1, 2027, would require states to check monthly if a Medicaid provider's or supplier's participation in Medicare, CHIP or another state's Medicaid program is still active. ***Potential CalOptima Health Impact:*** Improved accuracy of provider enrollment data from DHCS.	**09/17/2024** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 819 Eggman	**Medi-Cal Mobile Health Care Site Enrollment:** Would exempt intermittent or mobile health care sites from enrolling in Medi-Cal as a separate provider if operated by a government-operated clinic that is exempt from licensure by the California Department of Public Health (CDPH). ***Potential CalOptima Health Impact:*** Expansion of intermittent and mobile health care sites; increased access to care for CalOptima Health members.	**09/22/2024** Signed into law	CalOptima Health: Watch
SB 1268 Nguyen, J.	**Medi-Cal Safety Net Provider Contracts:** Would require a Medi-Cal MCP to offer and maintain a network provider contract with each safety net provider operating within the MCP's geographic service areas unless the safety net provider cannot provide necessary scope of services due to specified, covered reasons. Would prohibit a Medi-Cal MCP from initiating a contract termination for any reason. ***Potential CalOptima Health Impact*:** Revision of current provider contract language; decreased oversight and accountability of contracted providers.	**04/26/2024** Died in Senate Health Committee	**04/15/2024** CalOptima Health: OPPOSE LHPC: Oppose CAHP: Oppose
AB 236 Holden	**Provider Directory Audits:** Would require health plans to annually verify and delete inaccurate listings from its provider directories. Would also require a provider directory to be 60% accurate by July 1, 2025, with increasing percentage accuracy each year until the directories are 95% accurate by July 1, 2028. In addition, plans would be subject to penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. Further, beginning July 1, 2025, would require plans to delete a provider from its directory if a plan has not reimbursed the provider in the prior year. Would also require a plan to arrange care for all covered health services provided to a beneficiary who reasonably relied on inaccurate, incomplete or misleading information contained in a plan's provider directory as well as require the plan reimburse the provider the contracted amount for those services. ***Potential CalOptima Health Impact:*** Increased oversight of CalOptima Health provider directory; increased coordination with contracted providers; increased penalty payments to DHCS.	**08/16/2024** Died in Senate Appropriations Committee **06/26/2024** Passed Senate Health Committee **01/30/2024** Passed Assembly floor	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
AB 564 Villapudua	**Medi-Cal Claim Signatures**: Would allow Medi-Cal providers to submit electronic signatures for claims and remittance forms. ***Potential CalOptima Health Impact:*** Reduced administrative burden for CalOptima Health contracted providers.	**07/03/2024** Died in Senate Health Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2110 Arambula	**Adverse Childhood Experiences (ACEs) Trauma Screenings:** Would include Medi-Cal enrolled community-based organizations and local health jurisdictions that provide health services through community health workers and doulas as providers qualified to provide and eligible to receive payments for ACEs trauma screenings. **Potential CalOptima Health Impact:** Increased access to care for eligible CalOptima Health Medi-Cal members; additional provider contracting and credentialing.	**05/17/2024** Died in Assembly Appropriations Committee **04/09/2024** Passed Assembly Health Committee	CalOptima Health: Watch LHPC: Support
AB 2129 Petrie-Norris	**Immediate Postpartum Contraception:** No later than January 1, 2025, would authorize a provider to separately bill for devices, implants or professional services, or a combination of both, associated with immediate postpartum contraception if the birth takes place in a general acute care hospital or licensed birth center. ***Potential CalOptima Health Impact:*** Modified Claims procedures for a covered Medi-Cal benefit.	**09/29/2024** Signed into law	CalOptima Health: Watch
AB 2339 Aguiar-Curry	**Medi-Cal Asynchronous Telehealth:** Would expand telehealth capabilities to include asynchronous electronic transmission initiated directly by patients, including through mobile telephone applications. Would also authorize a health care provider to establish a new patient relationship using asynchronous store and forward when the visit is related to sensitive services. ***Potential CalOptima Health Impact:*** Expanded telehealth capabilities for CalOptima Health Medi-Cal members.	**09/20/2024** Vetoed *(see **veto message**)*	CalOptima Health: Watch
AB 2726 Flora	**Telehealth and Specialty Care Networks:** Would require CalHHS to establish a demonstration project for a grant program aimed at facilitating telehealth and other virtual services specialty care network for patients of certain safety-net providers, including community health centers and critical access hospitals. The project would focus on increasing access to behavioral and maternal health services as well as other specialties prioritized by CalHHS. ***Potential CalOptima Health Impact:*** Expanded telehealth capabilities and virtual specialty networks.	**05/17/2024** Died in Assembly Appropriations Committee **04/23/2024** Passed Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Rates & Financing			
S. 570 Cardin (MD) **H.R. 1342** Barragan (CA)	**Medicaid Dental Benefit Act of 2023:** Would require state Medicaid programs to cover dental and oral health services for adults. Would also increase the Federal Medical Assistance Percentage (FMAP) (i.e., federal matching rate) for such services. CMS would be required to develop oral health quality and equity measures and conduct outreach relating to dental and oral health coverage. ***Potential CalOptima Health Impact:*** Increased payments to CalOptima Health and contracted providers; additional quality metrics.	**02/28/2023** Introduced; referred to committees	CalOptima Health: Watch
S. 1038 Welch (VT) **H.R. 1613** Carter (GA)	**Drug Price Transparency in Medicaid Act of 2023:** Would prohibit "spread pricing" for payment arrangements with PBMs under Medicaid. Would also require a pass-through pricing model that focuses on cost-based pharmacy reimbursement and dispensing fees. ***Potential CalOptima Health Impact*:** Lower costs and increased transparency in drug prices under the Medi-Cal Rx program,	**03/29/2023** Introduced; referred to committees	CalOptima Health: Watch
S. 3578 Cassidy (LA)	**Protect Medicaid Act:** Would prohibit federal funding for the administrative costs of providing Medicaid benefits to individuals with unsatisfactory immigration status. If states choose to self-fund such costs, this bill would require states to submit a report describing its funding methods as well as the process utilized to bifurcate its expenditures on administrative costs. ***Potential CalOptima Health Impact:*** New financial reporting requirements.	**01/11/2024** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
H.R. 485 McMorris (WA)	**Protecting Health Care for All Patients Act of 2023:** Would prohibit all federally funded health care programs from using quality-adjusted life years (i.e., measures that discount the value of a life based on disability) to determine coverage and payment determinations for treatments and prescription drugs. ***Potential CalOptima Health Impact:*** Modified authorization limits for certain CalOptima Health members.	**02/07/2024** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 282 Eggman	**FQHCs and Rural Health Clinic (RHC) Same-Day Visits**: Would authorize reimbursement for a maximum of two separate visits that take place on the same day at a single FQHC or RHC site, whether through a face-to-face or telehealth-based encounter (e.g., a medical visit and dental visit on the same day). In addition, would add a licensed acupuncturist within those health care professionals covered under the definition of a "visit." ***Potential CalOptima Health Impact:*** Timelier access to services at CalOptima Health's contracted FQHCs.	**08/16/2024** Died in Assembly Appropriations Committee **07/11/2023** Passed Assembly Health Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch LHPC: Support
SB 340 Eggman	**Eyeglasses Reimbursement**: Would authorize a provider to purchase eyeglasses from a private entity instead of from the Prison Industry Authority for the purpose of Medi-Cal reimbursement for covered optometric services. ***Potential CalOptima Health Impact:*** Timelier access to prescription eyeglasses for CalOptima Health Medi-Cal members.	**07/03/2024** Died in Assembly Health Committee and Assembly Public Safety Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch
SB 828 Durazo	**Health Care Workers Minimum Wage Delay:** Would delay the minimum wage adjustments enacted pursuant to SB 525 (2023) by one month from June 1, 2024, to July 1, 2024, effective immediately as an urgency statute. ***Potential CalOptima Health Impact:*** No expected impact since CalOptima Health previously increased its minimum wage.	**05/31/2024** Signed into law	CalOptima Health: Watch
SB 870 Caballero	**MCO Tax:** Would renew the MCO tax on health plans, which expired on January 1, 2023, to an unspecified future date. Would also modify the tax rates to unspecified percentages that are based on the Medi-Cal membership of the health plan. ***Potential CalOptima Health Impact:*** Increased tax liability on CalOptima Health.	**01/19/2024** Died in Senate Appropriations Committee **04/26/2023** Passed Senate Health Committee	CalOptima Health: Watch
SB 1423 Dahle	**Rural Hospital Technical Advisory Group:** Would require DHCS to convene a Rural Hospital Technical Advisory Group — including representatives from Medi-Cal MCPs and their state associations — to analyze the ability of small, rural and critical access hospitals to remain financially viable under existing Medi-Cal reimbursement methodologies and to provide related recommendations by March 31, 2026. ***Potential CalOptima Health Impact:*** CalOptima Health representation on DHCS committee; consideration of modified payments to CalOptima Health contracted critical access hospitals.	**09/22/2024** Vetoed *(see **veto message**)*	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 1492 Menjivar	**Private Duty Nursing Rate Increases:** Would add private duty services, which are provided to a child under 21 years of age by a home health agency, as an eligible category for the purpose of Medi-Cal rate increases from MCO tax revenue. ***Potential CalOptima Health Impact:*** Increased payments to CalOptima Health contracted home health agencies.	**05/17/2024** Died in Senate Appropriations Committee **04/24/2024** Passed Senate Health Committee	CalOptima Health: Watch
AB 55 Rodriguez	**Ground Ambulance Transportation**: Effective January 1, 2024, would require Medi-Cal MCPs to implement a value-based purchasing model that increases reimbursement to ground ambulance transportation providers who meet certain workforce standards. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health's contracted transportation providers; increased costs for CalOptima Health.	**01/19/2024** Died in Assembly Appropriations Committee **04/25/2023** Passed Assembly Health Committee	CalOptima Health: Watch
AB 488 Nguyen, S.	**Vision Loss:** Would modify the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program measures and milestones to include program access, staff training and capital improvement measures aimed at addressing the needs of SNF residents with vision loss. ***Potential CalOptima Health Impact:*** Modified payments to CalOptima Health contracted SNFs; increased data collection, tracking and reporting requirements; improved quality of life for certain members with vision loss.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1549 Carrillo	**FQHC and RHC Rates:** Would require that DHCS's per-visit rates to FQHCs and RHCs account for costs that are reasonable and related to the provision of covered services, including staffing, the intensity of activities taking place in an average visit, the length or duration of a visit, and the number of activities provided during a visit. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health's contracted FQHCs.	**01/19/2024** Died in Assembly Appropriations Committee **04/25/2023** Passed Assembly Health Committee	CalOptima Health: Watch
AB 1698 Wood	**Medi-Cal Funding**: States the intent of the Legislature to enact future legislation to increase overall funding and reimbursement for the Medi-Cal program. ***Potential CalOptima Health Impact***: Increased financial stability for CalOptima Health and its contracted providers.	**01/19/2024** Died without referral to committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2043 (AB 719) Boerner	**Public Transit Contracts**: Would authorize DHCS to direct Medi-Cal MCPs to reimburse public paratransit service operators, who are enrolled as Medi-Cal providers, at the Medi-Cal FFS rates for nonmedical transportation (NMT) and nonemergency medical transportation (NEMT) services that are not on fixed routes. Would also direct DHCS to issue updated guidance by June 1, 2026, to ensure that the financial burden of these services is not unfairly placed on such operators. ***Potential CalOptima Health Impact:*** Increased payments to public paratransit operations for NMT and NEMT services.	**08/16/2024** Died in Senate Appropriations Committee **06/12/2024** Passed Senate Health Committee **05/21/2024** Passed Assembly floor **02/01/2024** Re-introduced as AB 2043 **10/07/2023** Vetoed as AB 719 *(see **veto message**)*	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
AB 2303 Carrillo	**Minimum Wage Add-On Payment:** Would require DHCS to develop a minimum wage add-on as an alternative payment methodology to increase rates of payment to community health centers, in order to accommodate increased labor costs resulting from recently enacted minimum wage increases pursuant to SB 525 (2023). ***Potential CalOptima Health Impact***: Increased financial stability for CalOptima Health contracted community health centers.	**04/26/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 2342 Lowenthal	**Island-Based Critical Access Hospitals:** Would require DHCS to provide an annual supplemental payment for covered Medi-Cal services to each critical access hospital that operates on an island that is located more than 10 miles offshore of the mainland coasts of the state but is still within the jurisdiction of the state. ***Potential CalOptima Health Impact:*** Increased payments to certain critical access facilities for Medi-Cal services.	**04/26/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 2428 Calderon	**Community-Based Adult Services (CBAS) Rates:** Would require Medi-Cal MCPs to reimburse contracted CBAS provider at an amount equal to or greater than the Medi-Cal FFS rate. ***Potential CalOptima Health Impact:*** Increased payments to CalOptima Health contracted CBAS providers.	**09/14/2024** Vetoed *(see **veto message**)*	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 3275 Soria	**Claim Reimbursement:** Beginning January 1, 2026, would require health plans to reimburse, contest or deny a complete claim within 30 calendar days after receipt of the claim, or otherwise be subject to current 15% per annum interest requirements. If a plan does not automatically include any accrued interest in its payment, this bill would increase the penalty fee from $10 to the greater of $15 or 10% of accrued interest. In addition, would require health plans to treat a complaint from an enrollee about the delay or denial of a claim payment to be treated as a grievance, regardless of whether the term grievance is used. ***Potential CalOptima Health Impact*:** Decreased claim review time for CalOptima Health staff; increased number of member grievances; increased interest and penalty payments to CalOptima Health contracted providers.	**09/27/2024** Signed into law	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
Social Determinants of Health			
H.R. 1066 Blunt Rochester (DE)	**Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2023:** Would require CMS to update guidance at least once every three years to help states address SDOH under Medicaid and CHIP. ***Potential CalOptima Health Impact:*** Increased opportunities for CalOptima Health to address SDOH.	**02/17/2023** Introduced; referred to House Energy and Commerce Committee	CalOptima Health: Watch
AB 257 Hoover	**Encampment Restrictions:** Would prohibit a person from sitting, lying, sleeping or placing personal property in any street, sidewalk or other public property within 500 feet of a school, daycare center, park or library. ***Potential CalOptima Health Impact:*** Increased outreach and support services for unsheltered CalOptima Health Medi-Cal members.	**01/19/2024** Died in Assembly Public Safety Committee **03/07/2023** Failed passage in Assembly Public Safety Committee	CalOptima Health: Watch
AB 2250 (AB 85) Weber	**SDOH Screenings:** Would add SDOH screenings as a covered Medi-Cal benefit on or after January 1, 2027, contingent upon an appropriation by the Legislature. Would also require health plans to provide primary care providers with adequate access to community health workers, social workers and peer support specialists. In addition, would require FQHCs and RHCs to be reimbursed for these services at the Med-Cal FFS rate. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**09/22/2024** Vetoed *(see **veto message**)*	CalOptima Health: Watch LHPC: Support

2023 Signed Bills

- H.R. 3746 (McHenry [NC])
- H.R. 5860 (Granger [TX])
- H.R. 6363 (Granger [TX])
- SB 43 (Eggman)
- SB 101 (Skinner)
- SB 311 (Eggman)
- SB 326 (Eggman)
- SB 525 (Durazo)
- SB 496 (Limón)
- SB 770 (Wiener)
- AB 102 (Ting)
- AB 271 (Quirk-Silva)
- AB 557 (Hart)
- AB 118 (Committee on Budget)
- AB 119 (Committee on Budget)
- AB 531 (Irwin)
- AB 425 (Alvarez)
- AB 847 (Rivas, L.)
- AB 904 (Calderon)
- AB 1481 (Boerner)
- AB 1241 (Weber)

2023 Vetoed Bills

- SB 257 (Portantino)
- SB 694 (Eggman)
- AB 608 (Schiavo)
- AB 1060 (Ortega)
- AB 1202 (Lackey)
- AB 931 (Irwin)
- AB 576 (Weber)
- AB 1085 (Maienschein)
- AB 1451 (Jackson)

Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association
SNP Alliance: Special Needs Plan Alliance

Last Updated: November 25, 2024

2024 Federal Legislative Dates

January 8	118th Congress, 2nd Session convenes
August 5–September 6	Summer recess
September 30–November 11	Fall recess
December 20	118th Congress adjourns

Source: Floor Calendars, United States Congress: https://www.congress.gov/calendars-and-schedules

2024 State Legislative Dates

January 3	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
January 12	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2023
January 19	Last day for any committee to hear and report to the floor any bill introduced in that house in 2023
January 31	Last day for each house to pass bills introduced in that house in 2023
February 16	Last day for legislation to be introduced in 2024
March 21–March 30	Spring recess
April 26	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2024
May 3	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house in 2024
May 17	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house in 2024
May 20–24	Floor session only
May 24	Last day for each house to pass bills introduced in that house in 2024
June 15	Budget bill must be passed by midnight
July 3	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 3–August 4	Summer recess
August 16	Last day for fiscal committees to report bills in their second house to the Floor
August 19–31	Floor session only
August 23	Last day to amend bills on the Floor
August 31	Last day for each house to pass bills; final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2024 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).

Fiscal Year 2024–25 Enacted State Budget

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Background

On January 10, Gov. Gavin Newsom unveiled his Fiscal Year (FY) 2024–25 Proposed State Budget. With a spending plan of $291.5 billion ($223.6 billion General Fund [GF]), the governor predicted a budget deficit of $37.9 billion – about half the $68 billion initially projected by the Legislative Analyst's Office last year. Gov. Newsom attributed the past two years' shortfall to stock market declines in 2022, driving down revenue and delays in income tax collection. Most proposed budget solutions included reserve withdrawals, loans, fund shifts, and spending delays and deferrals.

To immediately address some of the budget deficit, the administration and California State Legislature attempted to minimize $17.3 billion of the overall shortfall by taking "early action" in April via a limited budget agreement that included some spending cuts that largely avoided health care programs.

Despite efforts in the early budget deal, revenues continued to come in below projections and further increase the deficit by an estimated $7 billion for a new remaining total of $27.6 billion. On May 10, Gov. Newsom released his May Revision to the Proposed State Budget, which largely reversed an agreement to fund Medi-Cal provider rate increases using Managed Care Organization (MCO) tax dollars. The May Revision also proposed several additional spending reductions to health care programs to address both the near-term budget deficit and look beyond FY 2024-25 in hopes of achieving positive operating reserves in the future. On May 29, leaders from both houses of the Legislature released a joint counterproposal to the May Revision, which would have instead delayed future rate increases funded by MCO tax revenues by one-year year from January 1, 2025, to January 1, 2026, rather than eliminate them. On June 13, the State Senate and State Assembly both passed its counterproposal (Assembly Bill [AB] 107) as a placeholder budget to meet the constitutional deadline while negotiations with the governor remained ongoing.

On June 22, Gov. Newsom and legislative leaders announced that a final budget agreement had been reached. After both houses of the Legislatures passed the agreed-upon budget revisions as Senate Bill (SB) 108 on June 26, Gov. Newsom signed both AB 107 and SB 108 into law. Additionally, the governor signed the MCO Tax Trailer Bill (AB 160) and consolidated Health Trailer Bill (SB 159) on June 29, containing policy changes needed to implement health-related budget expenditures. Together, these bills represent the FY 2024-25 Enacted State Budget.

Overview

The final budget agreement includes obligations to support further resilience by adding financial protection so that the state doesn't overcommit anticipated revenues until it has been completely realized. The enacted budget eliminates the projected FY 2024-25 shortfall of approximately $45 billion and the FY 2025-26 shortfall of over $30 billion through a combination of spending cuts, fund shifts, delays, deferrals and reserves, including utilizing approximately half of the Rainy Day Fund over the next two budget years. Another goal of the final budget agreement is to strengthen the Rainy Day Fund by increasing the maximum limit from 10% to 20% of GF tax revenue, subject to future voter approval, and creating a new "Projected Surplus Temporary Holding Account."

The final Medi-Cal budget includes $161 billion ($35 billion GF) to cover a projected 14.5 million beneficiaries in FY 2024-25 – more than one-third of the state's population.

MCO Provider Tax

The FY 2024-25 Enacted Budget restores several MCO tax investments for future Medi-Cal provider rate increases that were proposed to be eliminated in the governor's May Revision. The final agreement includes $133 million in FY 2024-25, $728 million in FY 2025-26 and $1.2 billion in FY 2026-27 in addition to the approximately $300 million in provider rate increases that already became effective January 1, 2024, and will be maintained. However, total investments are less and partially redistributed compared with the original agreement reached with the MCO tax coalition last year. Some increases will still be effective on January 1, 2025, some will be delayed until January 1, 2026, and others have been eliminated. Additional provider types not included in the MCO tax coalition will now also receive a portion of the investments, further reducing total funding for the originally included provider types.

Effective **January 1, 2025**, Medi-Cal rate increases apply to:

- Emergency Department Physician Services ($100 million)
- Abortion Care and Family Planning ($90 million)
- Ground Emergency Medical Transportation ($50 million)
- Air Emergency Medical Transportation ($8 million)
- Community-Based Adult Services ($8 million)
- Congregate Living Health Facilities ($8 million)
- Pediatric Day Health Centers ($3 million)
- Community Health Workers to achieve 100 percent of Medicare rate

Effective **January 1, 2026**, Medi-Cal rate increases apply to:

- Physician/Non-Physician Professional Health Services ($753 million)
  - » Evaluation & Management Codes for Primary Care and Specialist Office Visits, Preventative Services and Care Management (95% of Medicare rate)
  - » Obstetric Services (95% of Medicare rate)
  - » Non-Specialty Mental Health Services (87.5% of Medicare rate)
  - » Vaccine Administration (87.5% of Medicare rate)
  - » Vision (Optometric Services (87.5% of Medicare rate)
  - » Other Evaluation & Management Codes (80% of Medicare rate)
  - » Other Procedure Codes commonly utilized by Primary Care, Specialist and Emergency Department Providers (80% of Medicare rate)
- Private Duty Nursing ($62 million)
- Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs) ($50 million)
- Non-Emergency Medical Transportation ($25 million)

The final agreement allows the California Department of Health Care Services (DHCS) to develop specific rate increase methodologies and supplemental payment amounts, particularly for 2025 investments.

Additional MCO tax investments include $145.4 million in FY 2024-25 to sustain Proposition 56-funded payments to address revenue decline and $40 million in FY 2026-27 for Medi-Cal workforce development through the California Department of Health Care Access and Information (HCAI). The final agreement also includes funding to enact continuous Medi-Cal eligibility for children 0-5, effective January 1, 2026. Notably, if Proposition 35 ("Protect Access to Care" MCO Tax Initiative) is approved by voters in the November 5, 2024, general election, the aforementioned provisions relating to the MCO provider tax will be inoperable since both are not financially sustainable.

CalOptima Health Budget and Provider Rate Increase

CalOptima Health developed our proposed FY 2024-25 operating budget factoring in assumptions related to Medi-Cal program and policy changes, including the state budget. On May 2, the CalOptima Health Board of Directors approved an investment of **$526 million** to increase rates paid to delegated networks, hospitals, physicians, community clinics, behavioral health providers and ancillary services providers. It is the largest provider rate increase of its kind in our nearly 30-year history. This unprecedented investment is intended to support timely access to critical health care services for members and promote longer-term financial stability of the managed care network over a 30-month period from July 2024 to December 2026. The uncertain nature of the state budget negotiations underscores why CalOptima Health's action to deliver our own separate provider rate increase is so significant.

Continuing Priorities in Medi-Cal

The enacted state budget continues to reflect funding for Medi-Cal benefits that were initially proposed to be eliminated in the May Revision. Key investments that have been protected include but are not limited to:

- Full-scope Medi-Cal coverage and In-Home Supportive Services (IHSS) for all ages, regardless of immigration status.
- **Adult Acupuncture** as a Medi-Cal covered benefit.
- Continued funding for **Health Enrollment Navigators** at clinics, but not at other entities. This does not impact CalOptima Health's own reserve-funded grants for community enrollers.
- **Free Clinics Augmentation** funding.
- Nearly all funding for the **Multifamily Housing Program**.

In addition, the final budget includes $230 million ($115 million GF) for a new directed payment program for children's hospitals to support critically ill children.

Significant Adjustments to Programs

To address the projected budget shortfall, the final budget includes several adjustments in the form of delays, triggers and reductions to certain programs and legislation that has not been implemented. Key program adjustments include but are not limited to:

- $39 million savings in the **Naloxone Distribution Project** from lower naloxone drug costs due to Medi-Cal Rx, while adding $8.3 million in special funds to expand the distribution of naloxone. This does not impact CalOptima Health's own reserve-funded naloxone distribution initiative.
- Reduced funding for **Equity and Practice Transformation (EPT) Program** payments by $111.3 million, which will eliminate the remaining funding for the program but preserve funding previously included in the 2022 Budget Act.
- Reverts all unexpended funds for the **Clinic Workforce Stabilization & Retention Payment Program**.
- Reduces or eliminates funding for several elements of the **Children and Youth Behavioral Health Initiative** (CYBHI), as follows:
  - » Eliminates funding for school-linked partnership and capacity grants for community colleges, University of California and California State University systems.
  - » Eliminates funding for the services and supports platform.
  - » Reduces funding for the public education and change campaign.
  - » Allows school districts to use a third-party administrator and/or managed care plans directly for billing related to the school-linked fee schedule.
  - » Despite overall reductions, allocates new funding to establish the **wellness coach** benefit, effective January 1, 2025, to provide wellness promotion, education, screening, care coordination, individual and group support, and crisis referral in school-linked settings and across the Medi-Cal behavioral health delivery system.
- Reduces some funding for state and local public health.
- Reverts $450.7 million from the last round of the **Behavioral Health Continuum Infrastructure Program**, which leaves $1.75 billion to support existing projects.
- Reduces and delays funding for **Behavioral Health Bridge Housing** by one year from FY 2024-25 until FY 2025-26.
- Ends continued funding for the **Medication Assisted Treatment** program, which funds startup grants for new treatment facilities.

Next Steps

State agencies, including DHCS, 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 August 31 to pass legislation, and Gov. Newsom has until September 30 to either sign or veto that passed legislation.

About CalOptima Health

CalOptima Health, a county organized health system (COHS), is the single plan providing guaranteed access to Medi-Cal for all eligible individuals in Orange County and is responsible for almost all medical acute services, including custodial long-term care. CalOptima Health is governed by a locally appointed Board of Directors, which represents the diverse interests that impact Medi-Cal.

If you have any questions, please contact GA@caloptima.org.

CalOptima Health Community Outreach Summary —November and December 2024

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 as well as supports our community partners' public activities. Participation includes providing Medi-Cal educational materials and, if criteria is 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 holiday season, CalOptima Health, in partnership with Congressman Lou Correa, is excited to host our first-ever Holiday Event on Saturday, December 14, from 9 a.m. to 1 p.m. at Valley High School in Santa Ana. Recognizing that the holidays can bring financial challenges for many CalOptima Health families, this event is designed to support our members and their families by featuring a toy and food distribution (while supplies last), provide Medi-Cal and CalFresh enrollment, as well as access to essential resources provided by local community partners. Together, we can spread holiday cheer and help meet the needs of our members and the local community.

Summary of Public Activities

As of November 6, CalOptima Health plans to participate in, organize or convene 56 public activities in November and December. In November, there were 33 public activities, including 13 virtual community/collaborative meetings, 17 community events, two community-based presentations and one Health Network Forum. In December, there will be 23 public activities, including 14 virtual community/collaborative meetings, seven community events, one Cafecito and one Health Network Forum. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided two endorsements since the last reporting period (e.g., 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 Korean Community Services, Inc. (d/b/a KCS Health Center) Fiscal Year 2025 Service Area Competition (SAC) application for continued designation as a Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC) Federally Qualified Health Center (FQHC) under section 330 of the Public Health Services Act.
2. Letter of support for Huntington Beach Union High School District and Huntington Beach Adult School's (HBAS) application for the High Road Training and Partnerships 2024-25 Healthcare Grant.

For additional information or questions, contact CalOptima Health Community Relations Director Tiffany Kaaiakamanu at 714-222-0637 or tkaaiakamanu@caloptima.org.

CalOptima Health

Attachment to the December 5, 2024 CalOptima Health Outreach Summary

Community events hosted by CalOptima Health and community partners in November and December 2024:

November 2024

November 1, 5:30–9 p.m., Day of the Dead, hosted by the City of Anaheim

Center Greens Park, 305 E. Broadway, Anaheim

- Sponsorship fee: $5,000; included a resource booth, banner displayed on stage, logo on flyers, postcards, social media posts and CalOptima Health name shared via emcee hourly announcements
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 2, 9 a.m.–1:30 p.m., Orange County Senior Expo, hosted by Golden Futures Expo

Sheraton Park Hotel, 1855 S. Harbor Blvd., Anaheim

- Registration fee: $595; included a resource booth, company identification sign, company listing in expo guide, company hyperlink on website and promotional items included in event bags
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 3, 7 a.m.–Noon, Dino Dash, hosted by the Tustin Public Schools Foundation

The Market Place, 2915 El Camino Real, Tustin

- Sponsorship fee: $2,500; included a resource booth, two event registrations and a VIP guest tent. A student created a Dino trophy, logo on t-shirt, emails, poster and website.
- At least one staff member attended (in person)
- Health/Resource fair, open to the public

November 5, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Lido Lane Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 6, 5–7 p.m., Parent Resource Fair, hosted by Orange County Department of Education

Harbor Learning Center North, 1240 N. Harbor Blvd., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

November 6 through 7, 8 a.m.–6 p.m., Fall Conference, hosted by the California Association of Adult Day Services

Hotel Fera Anaheim, 100 City Dr. S., Orange

- Sponsorship fee: $5,200; included a resource booth and two event registrations
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 7, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Provential/Bellevue Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 7, 6–7 p.m., CalOptima Health Medi-Cal Overview in English

Melinda Hoag Smith Center for Healthy Living, 307 Placentia Ave., Newport Beach

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

November 12, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Balsam/Curtis Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 13, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Clifton/Philadelphia Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 14, 8 a.m.–5 p.m., The Future of Health Care, hosted by Advance OC

UCI Beall Center for Applied Innovation, 5270 California Ave., Ste. 100, Irvine

- Sponsorship fee: $5,000; included a panelist speaking opportunity, and logo on flyers and website
- At least three staff members attended (in person)
- Health/Resource Fair, open to the public

November 14 through 15, 8 a.m.–5 p.m., Annual Conference, hosted by the American College of Healthcare Executives

Hilton Los Angeles, 555 Universal Hollywood Dr., Universal City

- Sponsorship fee: $3,000; included a resource table, listing in the conference brochure, logo on website and a complimentary pass
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

November 15, 8:30 a.m.–1:30 p.m., 2024 Women's Health Summit, hosted by University of California, Irvine

Beckman Center of the National Academies of Sciences & Engineering, 100 Academy Wy., Irvine

- Sponsorship fee: $2,500; included an exhibitors table, four tickets with preferred seating, logo recognition in event materials and website. Social media exposure and recognition from stage.
- At least four staff members attended (in person)
- Health/Resource Fair, open to the public

November 16, 7 a.m.–1 p.m., NAMI Walks, hosted by the National Alliance on Mental Illness (NAMI) of Orange County

Angel Stadium, 2000 E. Gene Autry Way, Anaheim

- Sponsorship fee: $2,500; included a resource table, logo and website link on the event website
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 16, 1–5 p.m., Thanksgiving Event, hosted by the Office of Santa Ana Mayor Pro Tem Thai Viet Phan

Cesar Chavez Campesino Park, 3311 W. 5th St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 19, 11 a.m.–Noon, CalOptima Health Medi-Cal Overview in English

Orange County Veterans and Military Families Health & Wellness Working Group, Virtual

- At least one staff member presented
- Community-based organization presentation, open to members/community

November 19, 2–4 p.m., Hunger and Homelessness Resource Fair, hosted by Santa Ana College

Pending

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 22, 9:30 a.m.–1:30 p.m., Enrollment Fiesta, hosted by Serve the People

Mexican Consulate, 2100 E. 4th St., Santa Ana

- Sponsorship fee: $25,000; included a resource table
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 23, 9 a.m.–1 p.m., Thanksgiving Open House and Food Distribution Event, hosted by CalOptima Health

CalOptima Health, 505 City Parkway W., Orange

- At least twenty staff members attended (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

December 2024

December 3, 9–10:30 a.m., Cafecito Meeting, hosted by CalOptima Health
CalOptima Health, 505 City Parkway W., Orange
- At least four staff members attended (in person)
- Steering committee meeting, open to collaborative members

December 3, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services
Provential/ Bellevue Neighborhood
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

December 5, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services
Avon/Eaton/Dakota Neighborhood
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

December 7, 10 a.m.–2 p.m., Annual Orange County Brain Health Awareness Holiday Luncheon, hosted by Advocates for African American Elders
Yost Theater, 307 N. Spurgeon St., Santa Ana
- Sponsorship fee: $2,500; includes a resource table and name listed as Community Partner Sponsor on outreach materials
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

December 7, 4:30– 8 p.m., Tree Lighting Ceremony, hosted by City of Fountain Valley
Fountain Valley Recreation Center & Sports Park, 16400 Brookhurst St., Fountain Valley
- Sponsorship fee: $500; includes a resource table, verbal recognition, company name on webpage/social media and in the Fountain Pen.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

December 8, 9 a.m.–3 p.m., Battle of Mariachis, hosted by the Power of One
Eddie West Stadium, 602 N. Flower St., Santa Ana
- Sponsorship fee: $10,000; includes a resource table, and a speaking opportunity
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

December 12, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services
Athena/Sunburst/ Neighborhood
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

December 14, 9 a.m.–1 p.m., Holiday Event, hosted by CalOptima Health in collaboration with Congressman Lou Correa

Valley High School, 1801 S. Greenville St., Santa Ana

- At least twenty staff members 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 CalFresh Outreach (e.g., colleges, food banks) Community Presentation
Exhibitor/Attendee

Board-Approved Strategic Initiatives Executive Summary – Report Period: July 2024-September 2024

CalOptima Health's Board of Directors has authorized $1,419.6 million in funding and investment in programs and strategic initiatives to improve community and member health and wellness. Detailed impact summary reports are attached.

Exhibit 1: Board Approved Initiatives (as of September 30, 2024)

Board-approved Initiatives	INITIATIVE LEADER	Program Status	Payment Status	Board Approved Amount	Spent Amount	Additional Amounts Committed	Resource Available	Duration
Community Outreach and Investments								
Adult Expansion Outreach Strategy	Thompson	In progress	In Progress	$ 5.0	$ 0.8	$ 2.6	$ 1.6	CY 2024
CalFresh and Redetermination Outreach	Thompson	In progress	In Progress	$ 6.0	$ 3.9	$ 0.3	$ 1.8	Ongoing
CalFresh Outreach Strategy	Thompson	In progress	In Progress	$ 2.0	$ 1.8	$ 0.20	$ (0.0)	Ongoing
CalOptima Health Community Reinvestment Program	Rose	Not yet started	Not yet started	$ 38.0	$ -	$ -	$ 38.0	CY 2024
Coalition of OC Community Health Centers	Laverdiere	In progress	In Progress	$ 50.0	$ 20.0	$ 30.0	$ -	FY 2023 - FY 2027
Community Living Project	Bruno-Nelson	In progress	In Progress	$ 18.0	$ 0.4	$ (0.0)	$ 17.6	FY 2024 - TBD
Garden Grove Recovery Center Development and Maintenance	Bruno-Nelson	In progress	In Progress	$ 10.5	$ 0.5	$ 10.0	$ -	FY 2024
General Awareness and Brand Development	Thompson	In progress	In Progress	$ 4.7	$ 3.4	$ 0.6	$ 0.7	Ongoing
Homeless Health Initiative	Bruno-Nelson	In progress	In Progress	$ 61.7	$ 44.6	$ 9.3	$ 7.8	Multiple
Hospital Data Exchange Incentive	Herman	Complete	Not yet started	$ 2.0	$ -	$ -	$ 2.0	TBD
Housing and Homelessness Incentive Program	Bruno-Nelson	In progress	In Progress	$ 87.4	$ 65.1	$ 21.7	$ 0.6	Multiple
In-Home Care Pilot Program	Dabbah	In progress	Not yet started	$ 2.0	$ -	$ -	$ 2.0	09/01/2023 - 08/31/2025
Member and Population Health Needs Assessment	Laverdiere	In progress	In Progress	$ 1.3	$ 0.2	$ 1.0	$ 0.0	FY 2024 - FY 2025
Mind OC Grant (Irvine)	Laverdiere	In progress	Complete	$ 15.0	$ 15.0	$ -	$ -	One-time (CY 2023 - CY 2024)
Mind OC Grant (Orange)	Laverdiere	In progress	Complete	$ 1.0	$ 1.0	$ -	$ -	One-time (FY 2022 - FY 2024)
Naloxone Distribution Event	Carpenter	In progress	In Progress	$ 15.0	$ 12.7	$ 0.3	$ 2.0	FY 2024
NAMI Orange County Peer Support Program	Katsarov	In progress	In Progress	$ 5.0	$ 1.5	$ 3.5	$ -	CY 2023 - CY 2027
OneCare Outreach and Engagement Strategy	Thompson	In progress	In Progress	$ 1.0	$ 0.3	$ 0.3	$ 0.4	04/01/2024 - 06/30/2024
Provider Workforce Development	Laverdiere	In progress	In Progress	$ 50.0	$ 4.4	$ 20.2	$ 25.4	FY 2024 - FY 2028
Stipend Program for Masters of Social Work	Laverdiere	In progress	Complete	$ 5.0	$ 5.0	$ -	$ -	FY 2024 - FY 2028
Virtual Care Strategy & Roadmap	Jeannis	Complete	Complete	$ 3.9	$ 3.0	$ -	$ 0.9	FY 2021
Wellness Prevention Program	Katsarov	In progress	In Progress	$ 2.7	$ 0.6	$ 2.0	$ -	FY 2024 - FY 2027
Subtotal				***$ 387.2***	***$ 184.4***	***$ 102.0***	***$ 100.7***	
Quality Incentive Programs								
Comprehensive Community Cancer Screening	Pitts	In progress	In Progress	$ 50.1	$ 5.5	$ 12.5	$ 32.1	CY 2023 - CY 2027
COVID-19 Vaccination Incentive	Lee	Complete	Complete	$ 35.6	$ 30.2	$ -	$ 5.4	FY 2020 - FY 2023
Dyadic Services Program Academy	Katsarov	In progress	In Progress	$ 1.9	$ 0.9	$ 1.0	$ -	04/30/2024 - 03/31/2026
Five-Year Hospital Quality Program	Lee	In progress	In Progress	$ 153.5	$ 20.6	$ 132.9	$ -	CY 2023 - CY 2027
Medi-Cal Annual Wellness Initiative	Lee	Complete	Complete	$ 3.8	$ 1.3	$ -	$ 2.5	FY 2023
OneCare Member Health Incentives	Lee	In progress	In Progress	$ 0.5	$ 0.3	$ -	$ 0.2	FY 2023
Post-Acute Infection Prevention Quality Initiative (PIPQI)	Dankmyer	Complete	Complete	$ 5.3	$ 4.6	$ -	$ 0.7	FY 2019 - FY 2022
Quality Initiatives from Unearned P4V Program	Lee	In progress	In Progress	$ 23.3	$ -	$ -	$ 23.3	FY 2024 - FY 2025
Subtotal				***$ 274.0***	***$ 63.4***	***$ 146.4***	***$ 64.2***	
Infrastructure and Capacity Building								
Digital Transformation Strategy (DTS)	Kim	In progress	In Progress	$ 100.0	$ 46.7	$ 22.4	$ 30.9	FY 2023 - FY 2025
IGT Administrative Withhold (staff to support IGT Program)	Laverdiere	In progress	In Progress	$ 2.0	$ 0.5	$ 1.5	$ -	Ongoing
Medi-Cal Provider Rate Increases	Kim	In progress	In Progress	$ 526.2	$ 52.6	$ 473.6	$ -	07/01/2024 - 12/31/2026
Post-Pandemic Supplemental*	Kim	Complete	In Progress	$ 107.5	$ 99.9	$ 7.6	$ -	FY 2024
Skilled Nursing Facility Access Program	Dabbah	In progress	Not yet started	$ 10.0	$ -	$ -	$ 10.0	FY 2024 - FY 2026
Whole Child Model (WCM) Program*	Huang	Complete	Complete	$ 12.8	$ 12.8	$ -	$ -	FY 2019
Subtotal				***$ 758.5***	***$ 212.6***	***$ 505.1***	***$ 40.9***	
Total				**$ 1,419.6**	**$ 460.3**	**$ 753.4**	**$ 205.9**	

* Past supplemental funding.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/12/2024	**Initiative Name:**	Adult Expansion Outreach Strategy	**Start Date:**	7/1/2024
Reporting Period:	Jul-Sep (Q1)			**End Date:**	9/30/2024
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$5.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health will implement the Adult Expansion Outreach Strategy to promote awareness and enrollment of eligible adults ages 26-49 into full-scope Medi-Cal, regardless of immigration status, and enrollment in other public assistance programs (i.e., CalFresh).	- April 2024 - June 2025: Advertising campaign to target Latino residents ages 26-54. - $500,000 allocated from other objectives to advertising. Used this money to expand media buys for disruptive/out-of-home strategies - Planning for initial buys was completed in FY24 (for placements April 2024 - June 2025). - Currently, AltaMed's Community Enroller contract is pending approval.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop a multimedia campaign in Spanish	Number of impressions/media buys	Expanded media buys include: OCTA interior buys ads, laundromat ads, medical clinic standees and food truck ads. These ads run May 2024 - June 2025 and will garner an additional 78 million impressions. Budget = $500,000; fully spent.
Conduct community outreach and enrollment events	Number of events hosted	25 community events on Medi-Cal expansion, investing $287,300. These events featured Medi-Cal outreach through verbal messaging, distribution of flyers and on-site community enrollers addressing public charge concerns at a CalOptima resource booth.
Increase awareness and enrollment in the Medi-Cal and CalFresh programs, with a focus on outreach to the undocumented population	Number of Community Enrollers	CalOptima Health's BOD approved 13 community organizations. To date, 12 community organizations and 34 Community Enrollers have been funded to provide assistance with Medi-Cal and CalFresh enrollment, in addition to assisting members who have not completed their Medi-Cal renewal packets.
Create a communications toolkit to promote Medi-Cal expansion	Completion of communications toolkit	Toolkit materials posted online at www.caloptima.org/CoverageForAll; materials for community partners will be printed and shipped.
CalOptima Health Mobile Unit	Mobile unit purchased by end of 2024	Community Relations is working with vendor managment on the RFP process and HR for two positions (Sr. Community Relations Specialist and Community Relations Specialist) to support outreach and education activities via the mobile units.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/19/2024	**Initiative Name:**	CalFresh and Redetermination Outreach	**Start Date:**	2/2/2023
Reporting Period:	Jul-Sep (Q1)			**End Date:**	Ongoing
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$6.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health Outreach Strategy to support Medi-Cal redetermination and enroll potentially eligible CalOptima Health members in the CalFresh program.	Key Accomplishments: - Ran an advertising campaign October 2023 to June 2024 in digital, print, radio, television and out-of-home - Funded 13 community organizations to have Community Enrollers for CalFresh and Medi-Cal enrollment Next Steps: - Use remaining funds to purchase continued advertising in support of Medi-Cal renewal and CalFresh enrollment

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop a comprehensive marketing and advertising campaigns to promote Medi-Cal redetermination.	Campaign development Number of impressions/media buys	Garnered nearly 220 million impressions for a Medi-Cal redetermination campaign on media buys worth $996,497 to date. Plans are in the works to restart the Medi-Cal renewal and CalFresh campaigns in 2025 to expend remaining funds.
Collaborate w/ key stakeholders by hosting community events focused on the Medi-Cal redetermination and CalFresh program throughout the county.	Number of community events Number of members served	CalOptima Health hosted or will host 6 CalFresh events at the Outlets of Orange and sponsored 25 events that encompassed Medi-Cal redetermination, CalFresh enrollment and Medi-Cal expansion, investing $287,300. Events had Medi-Cal and CalFresh verbal messaging and flyer distribution.
Fund Community Enrollers to support members with Medi-Cal renewals and enrollment in CalFresh.	Number of Community Enrollers	CalOptima Health funded 13 community organizations for Community Enrollers. To date, 12 organizations and 34 Community Enrollers are funded to provide Medi-Cal and CalFresh enrollment assistance, and support members who have not completed their Medi-Cal renewal packets. AltaMed's contract is pending.
Ensure as many members retain Medi-Cal coverage throughout the resumption of redetermination.	Membership retention	During the resumption of Medi-Cal redetermination, CalOptima Health members were disenrolled at lower rates than originally predicted, based on comprehensive outreach and ongoing advertising and communications.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/19/2024	**Initiative Name:**	CalFresh Outreach Strategy	**Start Date:**	3/3/20222
Reporting Period:	Jul-Sep (Q1)			**End Date:**	Ongoing
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$2.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalFresh Outreach Strategy is designed to enroll potentially eligible CalOptima Health members in the CalFresh program to promote food security.	Key Accomplishments: - Hosted 6 CalFresh events at the Outlets of Orange - Sponsored 25 community events with Community Enrollers for CalFresh enrollment assistance - Produced a comprehensive ad campaign that generated more than 400 million impressions over more than two years Next Steps: - Produce and distribute a CalFresh mailer direct to members who are not enrolled (planned for monthly in 2025)

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop a comprehensive marketing and advertising campaigns to promote enrollment in CalFresh.	Campaign development Number of impressions/media buys	CalOptima Health spent $239,135 on campaign development. We anticipate garnering more than 400 million impressions on a total media placement budget of $1,190,200 (April 2022 to December 2024).
Collaborate w/ key stakeholders by hosting community events focused on the CalFresh program throughout the county.	Number of community events Number of members served	CalOptima Health hosted or plans to host 6 CalFresh events at the Outlets of Orange and sponsored 25 events that encompass CalFresh enrollment, Medi-Cal redtermination and Medi-Cal expansion, investing $287,300. Events had CalFresh verbal messaging and flyer distribution.
Produce direct mail promoting the availability of CalFresh benefits.	Number of mailers sent	CalOptima Health sent direct mail to approximately 316,000 members, at a total cost of about $200,000. Another direct mail campaign is planned for 2025.
Increase enrollment in CalFresh program.	Number of members supported by CalFresh	Per SSA's most recent report in July 2024, there are approx. 472,833 CalOptima Medi-Cal cases and 363,939 cases without CalFresh and approximately 128,634 CalOptima Health cases enrolled in the CalFresh program. As of June 2024, 27.20% of CalOptima Health cases are enrolled in CalFresh.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/15/2024	**Initiative Name:**	CalOptima Health Community Reinvestment Program	**Start Date:**	11/1/2023
Reporting Period:	Jul-Sep (Q1)			**End Date:**	2026
Program Status:	Not Started	**Initiative Owner:**	Dr. Michaell Rose	**Approved Amount:**	$38.0 Million
Payment Status:	Not Started				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Beginning January 1, 2024, 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.	- BOD approved an initial commitment of up to $38 million to fund the Community Reinvestment Program on 10/5/2023. - DHCS requirement for Community Reinvestment Program planning to start in CY24, with activities starting in CY2026. - DHCS distributed draft All Plan Letter (APL) 24-XXX Community Reinvestment Requirements for Managed Care Plans)MCP) review. - CalOptima Health provided comments on the draft All Plan Letter (APL) to DHCS in Sep 2024. - CalOptima Health has collaborated with the Local Health Plans of California to advocate to DHCS that the

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Establish Community Reinvestment Program governance	Governance established by Q1 2025, with implementation to begin Q2 2025	Not yet started
Develop Community Reinvestment Program activities and workplan	Workplan developed by Q2 2025	Not yet started - Funding opportunities will be released no earlier than Q3 of 2025, subject to DHCS requirements.
Engage Community Stakeholders and Quality Improvement and Health Equity Committees	Stakeholders committees convened	Not yet started

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/8/2024	**Initiative Name:**	Coalition of OC Community Health Centers	**Start Date:**	6/1/2022
Reporting Period:	Jul-Sep (Q1)			**End Date:**	6/30/2027
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$50.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Coalition's five-year, $50 million initiative with participating subgrantee community health centers to enhance access, quality, and further strengthen the safety net system across Orange County. The initiative focuses on building capabilities of participating clinics related to data and quality improvement, care delivery, and transitions towards value-based care.	-Year 1 focused on assessment of each health center on PHM and VBC capabilities informing implementation plans for 27 participating subgrantees. - Year 2 focused on guiding the clinic teams through the first year of project implementation. - Focus Year 3 on providing technical assistance to educate health centers on population health and value-based care. - Year 3 SOW and Budget plan submitted for review 10/2024; Progress monitoring of health center projects. - Designing subset cohort of clinics to receive enhanced support for focus on enhancing value-based care capacity and capabilities.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Provide monitoring, guidance, and support to subgrantee implementation projects from Year 1 to Year 3	% of planned milestones that have been successfully achieved within the specified timeframe	90% completed: Implemented project status reporting on a quarterly basis for participating health centers; Technical Assistance Providers created a clinic measures dashboard for tracking individual clinic project progress.
Provide timely technical assistance and support to subgrantees over 5 year grant period	Number of training workshops, webinars, and sessions conducted	50% completed: Technical Assistance Team (IHQC) provided Quality Improvement training and clinic-specific coaching calls regarding project status reporting.
Ensure data collection and reporting compliance over 5 year grant period	-Timely submission of reports by health centers -Completed implementation plan per clinic	50% completed: Participating clinics submitted Year 3 workplans and provided feedback via coaching meetings or on-site coaching sessions for workplan revisions.
Build the capacity of Coalition to support health centers in practice transformation and quality improvement from Years 2 to Year 5	-Positions outlined in the budget hired -% of Coalition staff completed technical assistance trainings	50% completed: Hired a data analyst; In process of hiring Program Managers for Healthcare Operations and Quality Management; Working with Curis Consulting to provide strategy development sessions for clinics.
Facilitate the exchange of knowledge and promising practices to advance population health and value-based care initiatives over 5 year grant period	-Policy briefs, white papers and publications created and disseminated	25% completed: Began capturing best practices; planning for activities at Year 3 Q2 Semi-Annual Convening

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/14/2024	**Initiative Name:**	Community Living Project	**Start Date:**	2/2023
Reporting Period:	Jul-Sep (Q1)			**End Date:**	TBD
Program Status:	In Progress	**Initiative Owner:**	Kelly Bruno-Nelson	**Approved Amount:**	$18.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Community Living Center will co-locate a recuperative care and PACE program designed specifically for unhoused older adults (55+ years) and primarily being discharged from hospitals in Orange County. The program will offer full on-site medical, dental, behavioral, and optical care with the option to reside at the center until permanently housed. Enrollment in the PACE program will continue post-discharge ensuring continued access to medical and social services, and tenancy services.	- CalOptima Health is currently working with broker to identify a building that will meet the programmatic needs of this project. - Meetings are being held with partner cities to explore potential sites. A meeting was held with the City of Garden Grove in October, and meetings with Anaheim and Santa Ana are scheduled for December.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Identify and secure a building and complete necessary renovation.	Close escrow on building. Complete architectural drawings and approvals. Secure a general contractor. Complete renovations.	Working with our broker to identify a building.
Ensure members discharged from the program are connected to permanent and/or supportive housing.	80% of older adults discharged from the program will be connected to permanent and/or supportive housing.	TBD
Ensure members discharged from the program continue to receive medical support from the PACE program.	75% of older adults discharged from the program will continue to receive PACE services.	TBD
Ensure members discharged from the program remain permanently housed.	75% of older adults discharged from the program will remain permanently housed 2 years post discharge.	TBD
Delivery of care to CalOptima Health Members who are eligible for the program.	75% of older adults in the program will successfully utilize the services offered	TBD

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/14/2024	**Initiative Name:**	Garden Grove Recovery Center Development and Maintenance	**Start Date:**	9/1/2023
Reporting Period:	Jul-Sep (Q1)			**End Date:**	TBD
Program Status:	In Progress	**Initiative Owner:**	Kelly Bruno-Nelson	**Approved Amount:**	$10.5 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Street Medicine Support Center is a service-enriched supportive housing facility focused on providing individuals enrolled in the Garden Grove Street Medicine Program with continued medical wrap around services, housing navigation, and Enhanced Care Management. These services will assist in retaining housing, improving health status, and maximizing the ability to live and (if applicable) work in the community. There will be 50 furnished, private rooms and an outdoor space for socialization and overall mental wellness.	- Architect procurement process has been completed and an architect has been chosen. - Currently finalizing the architect contract with an expected signing by 12/1/24. - Next steps will include meeting with the City of Garden Grove planning department to confirm planning process next steps.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Secure Architectural firm and complete design and plan approval process	Firm contracted and plans approved by City of Garden Grove	Architect has been identified and currently in the contracting process.
Complete Construction	Certificate of Occupancy secured date	Once the architectural work is complete, we will start the process of identifying a general contractor. This will include the construction timeline that will outline the estimated completion date.
Secure a provider	Contract with HealthCare in Action successfully executed	Will begin the process of securing a provider once the construction timeline is developed.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/12/2024	**Initiative Name:**	General Awareness and Brand Development	**Start Date:**	4/1/2023
Reporting Period:	Jul-Sep (Q1)			**End Date:**	6/30/2026
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$4.7 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
To create and implement a General Awareness and Brand Development campaign that will support enhanced recognition of CalOptima Health's key role in the community, improve understanding of our values and vision, and contribute to the strategic priority of promoting CalOptima Health's voice and influence. The audience for this campaign includes members, providers, community stakeholders, elected officials, CalOptima Health staff and the general public.	- Initial allocation of $2.7 million for this initiative was fully spent and executed by June 2024. - The success of the initiative provided evidence for the continued support of the campaign, garnering the BOD's approval of an additional $2.0 million for use in FY25 and FY26.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Brand platform development and consulting	Research, strategy, brand messaging and design platforms, brand concept and guidelines	- Completed a refresh of the General Awareness and Brand Campaign spending $250,000 on new campaign assets.
Campaign creation and execution	Media plan, campaign development and campaign production	- Original campaign assets/ads were completed in FY23 - Refreshed campaign creatives were developed Jul-Sep 2024 for print and digital media ads (TV/video, digital banner and social media ads) in partnership with Maricich Health.
Campaign media buys	Media placements, monitoring and reporting	- Original media plan was developed in FY23 and executed in FY23-FY24. - Media plan for additional funds was developed. - Ad placements started in Jul 2024 for digital media and Nov 2024 for print media. - Projected media spend for FY25 is $1,000,000.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/14/2024	**Initiative Name:**	Homeless Health Initiative	**Start Date:**	2019
Reporting Period:	Jul-Sep (Q1)			**End Date:**	TBD
Program Status:	In Progress	**Initiative Owner:**	Kelly Bruno-Nelson	**Approved Amount:**	$61.7 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Homeless Health Initiative (HHI) began in 2019 when the Board of Directors established a fund to support programs that improved the health of members experiencing homelessness. This fund has supported many projects and programs and continues to support the Homeless Clinic Access Program (HCAP), Outreach and Engagement, and Street Medicine project. Overall, it is helping to increase access to medical services for our members.	- The Street Medicine program launched in two new cities; Costa Mesa and Anaheim. The team will be seeking board support to continue the expansion in the coming months. - HCAP continues to operate at 12 shelter sites through the partnership of six local community clinics and homeless shelter operators.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop two new programs and/or services to meet the unique needs of our members experiencing homelessness.	Program implementation	Developed and launched and continue to maintain the Homeless Clinic Access Program (HCAP) and the Street Medicine program.
Provide 200 participants with point of care service through the Garden Grove Street Medicine program.	Number of members served	338 members have been served by this program.
Connect 90% of members served through the Garden Grove Street Medicine program to enhanced care management and community supports.	Percent of members connected	97% of individuals enrolled in the Street Medicine program are enrolled in enhanced care management, community supports, or both.
Connect 80% of members served through the Garden Grove Street Medicine program to a primary care physician (PCP).	Percent of members connected	93% of members are actively connected to a PCP.
Connect 25% of members served through the Garden Grove Street Medicine program to housing.	Percent of members connected	11% of members have been connected to a shelter or permanent housing. This number continues to trend upwards as staff have time to build relationships with the members and identify potential housing for them.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/15/2024	**Initiative Name:**	Hospital Data Exchange Incentive	**Start Date:**	TBD
Reporting Period:	Jul-Sep (Q1)			**End Date:**	TBD
Program Status:	Complete	**Initiative Owner:**	Mike Herman	**Approved Amount:**	$2.0 Million
Payment Status:	Not Started				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
This initiative was created to support contracted Orange County hospital and skilled nursing facility (SNF) participation in electronic data exchange.	The intent of this initiative was already addressed through Operating expenses. Electronic Admissions, Discharge, and Transfer (ADT) data exchange is supported by CalOptima Health contracted services. CalOptima Health no longer has a need for these allocated funds. Funds will be returned.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
N/A	N/A	N/A

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/14/2024	**Initiative Name:**	Housing and Homelessness Incentive Program	**Start Date:**	04/01/22
Reporting Period:	Jul-Sep (Q1)			**End Date:**	TBD
Program Status:	In Progress	**Initiative Owner:**	Kelly Bruno-Nelson	**Approved Amount:**	$87.4 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
HHIP is a voluntary program that aimed to improve health outcomes and access to whole person care services by addressing housing insecurity and instability for the Medi-Cal population. Through this program, CalOptima Health earned $72.9 million of the $83 million for which it was eligible. These funds have been and will continue to be invested into the community to improve the experience of members at-risk for and experiencing homelessness.	• Awarded 123 grants in various stages of implementation. • Listening sessions were in progress and community stakeholders are providing substantial input on potential future community investments to address these issues. • DHCS has concluded the HHIP program so reporting is no longer required and no more funds are available to be earned. • Staff will continue to manage the active programs funded under this initiative. Next funding opportunity will be made available in Q1 of 2025.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Address housing insecurity and instability among Medi-Cal members.	Earn $83.7M in incentives	Earned $73 of the potential $83.7M (87%).
	Percentage increase / increased number of housed members among unhoused members	Increased percentage and number of unhoused members housed from 1.3% in June 2022 to 34.3% as of October 2023, representing 3,585 members.
	Percentage of members that stayed stably housed	51% of members who were previously unhoused remained stably housed through October 2023.
Expend all funds contributed to this effort.	Number of grant awards	123 grant awards have been made and are in various stages of implementation.

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CalOptima Health

Housing and Homeless Incentive Program Capital Investments: Status Report

Partner Organization (this column repeats on the next page)	HHIP NOFO Round	Address	SPA	Contract Execution Date	Contract End Date	Total Contract/ Agreement Amount
City of Anaheim - Housing and Community Development Department	2	9150 E. Orangewood Ave. Anaheim, CA 92802	North	12/1/2023	12/1/2024	$1,500,000.00
Community Action Partnership OC	1	10821, 10786, 10782, 10881 Garza Ave. (Senior Duplex units A and B), Anaheim, CA 92802 9301 Katella Ave. (Duplex units A and B), Anaheim, CA 92804	North	4/1/2023	3/31/2024	$98,340.00
The Salvation Army Orange County	1	1401 S. Salvation Pl., Anaheim, CA 92805	North	6/1/2023	3/31/2024	$4,100,000.00
Jamboree Housing Corporation	2	1108 N. Harbor Blvd., Santa Ana, CA 92703	Central	12/1/2023	12/1/2024	$4,721,241.00
National Community Renaissance of California	2	1314 N. Angelina Dr., Placentia, CA 92870	North	12/1/2023	12/1/2024	$1,334,677.00
WISEPlace	2	23220, 23238, 23240 Orange Ave. Lake Forest & 23301 La Glorieta	South	12/1/2023	12/1/2024	$1,000,000.00
Pathways of Hope OC	1	504/506 W. Amerige Ave., Fullerton, CA 92832	North	4/1/2023	3/31/2025	$1,500,000.00
Mercy Housing California	2	480 S. Batavia St., Orange, CA 92868	North	12/1/2023	12/1/2025	$1,500,000.00
Golden State Recuperative Care	3	150 Cecil Place, Costa Mesa, CA 92627	Central	6/1/2024	5/31/2034	$3,500,000.00
Mind OC/Be Well OC	3	7800 Marine Way, Irvine, CA 92618	South	6/1/2024	5/31/2034	$5,000,000.00
Shelter Providers of Orange County, Inc., DBA HomeAid Orange County	2	617, 625, 637 W. La Veta Ave., Orange, CA 92686	North	12/1/2023	12/1/2024	$1,400,000.00
Illumination Foundation	2	918 N. Bewley St., Santa Ana, CA 92703	Central	12/1/2023	12/1/2024	$3,000,000.00
Community Development Partners	2	2274 Newport Blvd., Costa Mesa, CA 92627	Central	1/1/2024	12/1/2025	$8,000,000.00
Kingdom Causes dba City Net	2	8694 Western Ave., Buena Park, CA 90620	North	12/1/2023	12/1/2024	$1,337,170.49
Friendship Shelter	1	2435 S. El Camino Real, San Clemente, CA 92672	South	4/1/2023	9/30/2025	$3,850,000.00
Anaheim Housing Authority	2	1251 N. Harbor Blvd., Anaheim, CA 92801	North	12/1/2023	12/1/2025	$3,878,420.00
City of Yorba Linda	2	5086 Avocado Circle, Yorba Linda, CA 92886	North	12/1/2023	12/1/2024	$3,100,000.00
Families Forward	2	1852 San Juan St., Tustin, CA 92780	Central	12/1/2023	12/1/2025	$2,500,000.00
American Family Housing	1	15081 Jackson St., Midway City, CA 92655 and 1400 Bristol, Costa Mesa, CA 92626	Central	6/1/2023	5/31/2026	$2,951,660.00
The Eli Home, Inc.	2	3175 W. Ball Road, Anaheim, CA 92804	North	12/1/2023	12/1/2026	$5,000,000.00
City of Anaheim/Anaheim Housing Authority	1	120 S. State College Blvd., Anaheim, CA 92806	North	5/1/2023	4/30/2026	$2,000,000.00
Korean Community Services dba KCS Health Center	1	13091 Galway St., Garden Grove, CA 92844	Central	4/1/2023	3/31/2026	$2,500,000.00
Hart Community Homes	3	220 N. Lemon St., Fullerton, CA 92832	North	6/1/2024	5/31/2034	$4,000,000.00
Illumination Foundation	3	3708 W. Washington St., Santa Ana, CA 92703	Central	6/1/2024	5/31/2034	$3,500,000.00
Casa Youth Shelter	3	10935 Reagan St., Los Alamitos, CA 90720	North	8/1/2024	7/31/2034	$4,000,000.00
Orange County Housing Finance Trust	1	N/A as these ADUs will be cross-county	ALL	5/1/2023	4/30/2027	$4,000,000.00
C&C Development	2	7101 Lincoln Ave., Buena Park, CA 90620	North	1/1/2024	12/1/2026	$8,000,000.00
City of Brea	2	323 N. Brea Blvd., Brea, CA 92821	North	12/1/2023	12/1/2027	$6,028,491.51

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CalOptima Health

Housing and Homeless Incentive Program Capital Investments: Status Report

Partner Organization	Projected Completion Date	Number of Units Proposed	Number of Units Completed	Previous Site Visit Dates	Next Site Visit Dates	Total Payments To Date	Total Payments Remaining	Grant Open or Closed
City of Anaheim - Housing and Community Development Department	12/30/2023	102	102	10/22/2024	04/22/2025	$1,500,000	$	Open
Community Action Partnership OC	3/31/2024	5	5	9/28/2023	N/A	$98,340.00	$	Closed
The Salvation Army Orange County	3/31/2024	72	72	6/22/2023	N/A	$4,100,000	$	Closed
Jamboree Housing Corporation	3/31/2024	91	91		11/20/2024	$4,721,241	$	Open
National Community Renaissance of California	7/30/2024	65	65	5/13/2024	12/2/2024	$1,334,677	$	Open
WISEPlace	12/1/2024	5			12/5/2024	$1,000,000	$	Open
Pathways of Hope OC	12/31/2024	15		2/13/2024	9/25/2024	$1,500,000	$	Open
Mercy Housing California	1/30/2025	50			12/9/2024	$1,500,000	$	Open
Golden State Recuperative Care	3/31/2025	30		7/31/2024	1/15/2025	$2,000,000	$1,500,000	Open
Mind OC/Be Well OC	5/31/2025	35			12/4/2024	$	$5,000,000	Open
Shelter Providers of Orange County, Inc., DBA HomeAid Orange County	6/30/2025	6		6/21/2024	11/19/2024	$1,400,000	$	Open
Illumination Foundation	6/30/2025	11		11/7/2024	5/7/2025	$3,000,000	$	Open
Community Development Partners	8/1/2025	87		9/18/2024	3/18/2025	$8,000,000	$	Open
Kingdom Causes dba City Net	8/15/2025	20			12/05/2024	$1,337,170	$	Open
Friendship Shelter	9/30/2025	11		10/30/2024	4/30/2025	$3,850,000	$	Open
Anaheim Housing Authority	9/30/2025	89		10/22/2024	4/22/2025	$3,878,420	$	Open
City of Yorba Linda	9/30/2025	66			11/13/2024	$3,100,000	$	Open
Families Forward	11/1/2025	8		10/31/2024	4/31/2025	$2,500,000	$	Open
American Family Housing	1/1/2026	111		10/31/2024	4/31/2025	$2,951,660	$	Open
The Eli Home, Inc.	2/1/2026	11			12/1/2024	$5,000,000	$	Open
City of Anaheim/Anaheim Housing Authority	3/31/2026	32		10/22/2024	4/22/2025	$2,000,000	$	Open
Korean Community Services dba KCS Health Center	3/31/2026	100		9/17/2024	3/17/2025	$2,500,000	$	Open
Hart Community Homes	5/30/2026	20		10/9/2024	4/9/2025	$	$4,000,000	Open
Illumination Foundation	5/30/2026	30		11/7/2024	5/7/2025	$1,895,575	$1,604,425	Open
Casa Youth Shelter	7/31/2026	14			12/12/2024	$	$4,000,000	Open
Orange County Housing Finance Trust	11/30/2026	34		11/30/2023	12/8/2024	$4,000,000	$	Open
C&C Development	1/30/2027	55		10/23/2024	4/23/2025	$8,000,000	$	Open
City of Brea	5/31/2027	40		10/29/2024	4/29/2025	$6,028,492	$	Open
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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/15/2024	**Initiative Name:**	In-Home Care Pilot Program	**Start Date:**	9/1/2023
Reporting Period:	Jul-Sep (Q1)			**End Date:**	8/31/2025
Program Status:	In Progress	**Initiative Owner:**	Dr. Zeinab Dabbah	**Approved Amount:**	$2.0 Million
Payment Status:	Not Started				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health has contracted with UCI to partner with home-based care Dispatch Health services to provide services to all CalOptima Health members assigned to a UCI FQHC with acute medical needs. The program provides same-day high acuity care, focused medical intervention within 24 to 72 hours post discharge, and hospital-at-home alternative care in lieu of hospitalizations.	- Established a process to identify members appropriate for referral. - Continuting to identify opportunities for ensuring appropriate utilization and payment is administered in order to expand the program to additional members at risk for hospitalization.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Improve access to in-home acute care	Number of members seen in in-home acute care	71 members were seen in in-home acute care that were referred by UCI FQHCs
Reduce emergency department (ED) visits by 20%	Percentage of members seen through in-home acute care instead of ED	47.3% reduction in ED visits for 71 patients seen in in-home care acute care
Achieve utilization of Dispatch Health by at least 10%	911 Diversion Rate	12.9% of members were diverted to Dispatch Health in place of 911 service
Reduce hospital observation stay by 10%	Observation Diversion Rate	5.2% of members seen by Dispatch Health were observed in ED
Reduce hospital admission by 10%	Hospital Diversion Rate	3.7% reduction of hospital admission for members seen by Dispatch

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/8/2024	**Initiative Name:**	Member and Population Health Needs Assessment	**Start Date:**	2024
Reporting Period:	Jul-Sep (Q1)			**End Date:**	2025
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$1.3 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Conduct a comprehensive Member and Population Health Needs Assessment (MPHNA) and Health Equity Asset Mapping (HEAM) to assess the whole-person health needs and preferences of CalOptima Health members, inform the development of programs and strategic approaches and to meet the requirements of the Medi-Cal Population Needs Assessment (PNA) and address health equity.	- The RFP for contractor/vendor will be released in the next 1-2 months. A competitive review process of responses will be conducted, and a recommended awardee will be presented to the Board of Directors for approval in early Q1 2025.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Support meeting the requirements of DHCS population health initiatives, e.g., Population Health Management Strategy, (PNA), and Medi-Cal Transformation initiatives.	Deployment of MPHNA	TBD - not yet started
Understand the detailed member and population needs of our member population and community.	Identify trends in population health and social needs of CalOptima Health members	TBD - not yet started
Identify opportunities to address identified member and population health needs	Identify at least three targeted interventions based on assessment findings	TBD - not yet started
Complete detailed community asset mapping	Detailed community asset mapping and list of community investment opportunities	TBD - not yet started

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Board-Approved Initiative Status and Impact Summary

Report Date:	11/8/2024	**Initiative Name:**	Mind OC Grant (Irvine)	**Start Date:**	12/1/2022
Reporting Period:	Jul-Sep (Q1)			**End Date:**	10/31/2024
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$15.0 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Mind OC received grant funding to support the construction of the second Be Well OC Campus in Irvine, CA to provide best-in-class mental health and substance abuse services to all, regardless of payer. The first phase of campus development will include 75,000 sq ft. of crisis care, outpatient and residential/short term treatment options. The services are planned to support a full continuum of care needs, and will offer programs for adults, adolescents, and families (through wraparound supports).	- Site readiness activities completed. Phased operational construction on track with building progress. - Targeting provider selection for SUD services 6 months prior to operationalization of services - October 2024 - COH requested the latest construction budget as part of ongoing grant monitoring. - COH will continue to monitor to verify objectives were achieved through program close; next report due 12/30/24.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Complete Package 1: Site Readiness activities, to prepare site for the construction of 75,000 square feet of the Be Well Irvine Campus – Phase 1	% of site readiness activities completed and scheduled	100% completed: Demolition, abatement, rough grading and future building pads completed by August 2023.
Complete Package 2 construction for Be Well OC Irvine Campus, and buildings ready for phased operational go-live.	% of building construction based on procurement and construction schedule	60% completed: Framing completed, roofing installation progressing, completion of sewer lines; Revised start/end dates for October 2023 / February 2025, with building open for services by March 2025; Delay due to time needed to connect site to future utilities coming in via Marine Way roadwork improvements.
Align public and private funding to execute on the capital financing needed for Phase 1 development, for a total of $86 million.	$ amount of secured capital financing for funding Phase 1 development	100% completed: $82.7M in cash; $3.2M secure via fund flow contract with County of Orange.
Facilitate the process of provider selection and contracting for service provision at the Campus	% completion of selection process and contracting for service providers	Procurement process for services has begun.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/8/2024	**Initiative Name:**	Mind OC: Be Well OC Orange Campus Intake & Admissions	**Start Date:**	3/1/2022
Reporting Period:	Jul-Sep (Q1)			**End Date:**	2/29/2024
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$1.0 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Be Well Orange Campus will build an intake and admissions coordination capability to best meet the needs of the community and ensure excellence in access, assessment, placement into care, and referrals when indicated. The intake and admissions team will work closely and collaboratively with OC Links and other County and CalOptima Health functions necessary to coordinate appropriate placement into care.	- Call Center Software for all calls to be routed through one line - HOPE Central - implemented June 2024. - Anticipated rollout of client and referral partner satisfaction surveys in Fall/Winter 2024. - Care Navigation program ended October 1, 2024. - Close-out procedures currently in progress, pending final close-out report review, November 2024.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Onboard program staff with one Intake Supervisor and two Intake Counselors to support Phase 1	-Position descriptions created for each role -Each position posted for recruiting -Number of qualified respondents for each position -Qualified candidate hired for each position	100% completed: 3 intake navigators and 1 supervisor were hired after April 2022.
Program staff are appropriately trained with ongoing professional development	-Training plans developed for each role -Necessary training completed by each staff member annually -Performance review completed annually	100% completed: Hired staff completed appropriate training with ongoing professional development.
All campus programs are accessible to all clients and referral partners via a single phone number.	-Monthly inbound call volume -Monthly volume of calls handled by intake team versus calls routed to campus providers or other programs	100% completed: 1) Call Center Software implementation began on June 11, 2024; 2) June 2024 – August 2024 call volume - 2,795 calls, averaged 967 calls per month; 3) 94% of callers who called for program admission were accepted to a program. 4) Contract terminated August 29, 2024
Adapt and/or augment monthly Campus dashboard to support intake program reporting needs	-Monthly dashboard produced and disseminated -Number of individuals and organizations that the dashboard is shared with	100% completed: 1) Salesforce was adapted to capture relevant data elements; 2) Developed and published monthly dashboards on Care Navigation Team impact to the community (Providers, Partners, and Community Stakeholders) through Exodus and HR360.
3,600 people served each year through intake and admissions coordination program for Be Well Orange Campus	-Monthly volume of clients served -Quarterly volume of outreach activities, including number of individuals and organizations reached -Client and referral partner satisfaction surveys	100% completed: 1) Served 5,074 unique clients; 2) Submitted 45 Medi-Cal enrollment applications; 3) Provided 720 clients to SUD referrals, 460 Mental Health referrals, 136 Housing and Shelter referrals

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/20/2024	**Initiative Name:**	Naloxone Distribution Event	**Start Date:**	07/01/23
Reporting Period:	Jul-Sep (Q1)			**End Date:**	07/01/25
Program Status:	In Progress	**Initiative Owner:**	Veronica Carpenter	**Approved Amount:**	$15.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health will implement the Naloxone Distribution initiative to increase access to Naloxone for members, with the goal of reversing fentanyl and opioid overdoses and saving lives.	Through partnerships with community based organizations (CBOs), providers, recovery coalitions, and direct member outreach, CalOptima Health will distribute Naloxone throughout the community.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
CalOptima Health will purchase 250,000 doses of naloxone for distribution	Purchase Kloxxado (8 ml prescription-strength naloxone)	$12,500,000 spent to obtain 250,000 doses of naloxone; storage costs have totaled $108,000 thus far.
CalOptima Health will conduct events and community outreach to distribute naloxone to members	Offer naloxone at community events in various places throughout the county	Through community events CalOptima Health has distributed 1,241 boxes of Naloxone to members. CalOptima Health provides access to doses of Naloxone at all community events.
CalOptima Health will engage providers, community organizations, city governments, public agencies, school districts and others in helping to distribute naloxone to member	Create a process for providers and other partners to obtain the naloxone using a distribution agreement	CalOptima Health established a process and held two provider/CBO events in June and October 2024, served 78 attendees, distributed 15,300 boxes. Created a delivery service to respond to requests.
CalOptima Health will create a training video and communications resources to promote naloxone distribution and education	Develop sharable resources for communications and education	Training video and FAQs are posted online at www.caloptima.org/naloxone (approximately $5,000 spent)
CalOptima Health established a partnership with recovery coalitions to provide access to Naloxone	Offer an ongoing and routine allocation of Naloxone for members who are affiliated with a recovery coaltion.	CalOptima Health has provided over 150,000 of Naloxone on an ongoing bases to Fetanyl Solutions. Out of the 80,588 boxes of the Naloxone remaining, 50,000 boxes will be allocated to recovery coalitions.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/8/2024	**Initiative Name:**	NAMI Orange County Peer Support Program	**Start Date:**	1/1/2023
Reporting Period:	Jul-Sep (Q1)			**End Date:**	12/31/2027
Program Status:	In Progress	**Initiative Owner:**	Carmen Katsarov	**Approved Amount:**	$5.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
NAMI pairs trained Peer Support Mentors with CalOptima Health members to provide tailored, social support and resource navigation from hospital inpatient stay/emergency room visit to six months post-discharge. Peer Support Mentors facilitate members in scheduling and attending follow-up primary care appointments (especially post-discharge).	**Information based on the semi-annual report from November 2023-April 2024. - Majority of staff were hired and trained within the first 6 months. Additional staff has been on-boarded to support the increased efforts to grow the program participation. - There are currently 7 Peer Advocates in the program with 3 of those being full time. - Current enrollment rate into the program = 58%. - COH and NAMI are partnering to further refine reporting metrics/analysis. COH to develop strategy to improve awareness to increase program participation to meet the program goals.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Facilitate behavioral health transitions from hospital to home/community	Facilitate behavioral health transitions for 65% of those who are referred to the program (N=eligible members referred from hospital or ED). Success = 2+ months	Current at 50%; NAMI to report more details next reporting period (semi-annual).
Support behavioral health integration through Peer facilitating Member connection to ECM.	NAMI Peer program, connect 75% of members eligible for ECM who aren't already receiving the benefit. (i.e., the member receives an authorization for ECM)	Currently at 79%; Exceeding the goal of 75%.
Improve CalOptima Health's HEDIS FUM1 measure	For members who are referred to the program 85% achieve a follow-up appointment either 7 or 30 days after hospital or ED discharge	Reporting in process; NAMI is meeting with BH and CalAIM teams for on-going report design. Last meeting is 10/8/24.
Reduce readmissions at psychiatric hospital through family and resource connection	25% reduction in psychiatric hospital admissions for members referred from the ED and having completed the program	Reporting in process; NAMI is meeting with BH and CalAIM teams for on-going report design. Last meeting is 10/8/24.
	25% reduction in psychiatric hospital re-admissions for members referred during an inpatient stay *Establish baseline during year 1*	Reporting in process; NAMI is meeting with BH and CalAIM teams for on-going report design. Last meeting is 10/8/24.

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Board-Approved Initiative Status and Impact Summary

Report Date:	11/12/2024	**Initiative Name:**	OneCare Outreach and Engagement Strategy	**Start Date:**	07/01/2024
Reporting Period:	Jul-Sep (Q1)			**End Date:**	09/30/2024
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$1.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Expansion of the CalOptima Health OneCare outreach and engagement strategy to enroll and retain eligible CalOptima Health members who are also enrolled in Medicare.	- The BOD (October 3, 2024; agenda item #11) authorized to extend the timeframe to implement the CalOptima Health OneCare outreach and engagement strategy to June 30, 2025. - The remaining budget of $630,000 was loaded to Communications' advertising budget to increase media buys.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Increase outreach for CalOptima Health OneCare through continuous and heavy presence in the market with a full range of advertising tactics.	Number of media buys	- Continued use of funds were approved in early October and available for use in late October. - Currently planning the media buys, which will start rolling out in December 2024.
Retain existing CalOptima Health OneCare members with targeted mailings.	Number of members retained	- Two mailers were sent to existing members complete in FY24. - Retention results are unknown at this time.
Increase direct mail outreach to prospective CalOptima Health OneCare members by customizing messages and segmenting the mailing for: FFS members, Members enrolled in another MA	Number of direct mailers sent to three segmented audiences.	- Funding for this objective will be reallocated. This objective will be removed from future quarterly reports. - NOTE: This strategy was implemented in October 2024 using regular FY25 budget funds.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/8/2024	**Initiative Name:**	Provider Workforce Development	**Start Date:**	12/1/2023
Reporting Period:	Jul-Sep (Q1)			**End Date:**	FY 2028-2029
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$50.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Provider Workforce Development initiative was approved to close gaps in Orange County's health care workforce and increase access to high-quality, equitable care for CalOptima Health members. The five initiatives include: educational investments to increase supply of health care professionals (non-physician), the Workforce Training & Development Innovation Fund, the Physician Recruitment Incentive Program, the Physician Loan Repayment Program, and the Orange County Health Care Workforce Development Collaborative.	- Approved limited change requests from two Round 1 Grantees: Chapman -updated to include returning students to receive scholarships; UCI-update disbursement schedule from one payment to over three quarters. -$5 M Round 2 Training and Development Innovation Fund application closed August 2024. - 44 applications received from health systems, health care provider organizations, and CBOs - Priority area for this round of funding is on increasing the behavioral health workforce serving CalOptima Health members. - 6 grantees with allocations totaling $5.1 M were recommended and approved by the CalOptima Health BOD on November 7, 2024.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Implement Educational investments to increase supply of health care professionals (non-physician)	Number of health professionals in an educational program and/or receiving financial support	Estimate of approximately 1,500 health professionals.
Launch Workforce Training & Development Innovation Fund	Number of behavioral heath care professionals receiving training and/or development	Estimate of approximately 230 behavioral health professionals.
Implement Physician Recruitment Incentive Program	Number of physicians recruited to close network gaps	TBD - has not started
Implement Physician Loan Repayment Program	Number of physicians receiving loan repayment awards	TBD - has not started
Develop Orange County Health Care Workforce Development Collaborative	Launched collaborative to increase the health care workforce in Orange County	TBD - has not started

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/8/2024	**Initiative Name:**	Stipend Program for Masters of Social Work	**Start Date:**	8/1/2023
Reporting Period:	Jul-Sep (Q1)			**End Date:**	7/31/2028
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$5.0 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Orange County Behavioral Health (OCBH) Master of Social Work Stipend Program will increase the public healthcare workforce from diverse backgrounds equipped to provide culturally and linguistically responsive care to communities in need. The program will provide a stipend of $20,000 per academic year for up to two (2) years to 36 MSW students each year at CSUF (as they receive enhanced didactic and experiential training).	- 36 students successfully completed the OCBH program for 2023-2024 academic year: 14 graduated May 2024; 21 students are continuing for their second year; 1 student chose not to continue with the stipend program - 15 grant recipients left the OCBH program with a one-year work commitment within Orange County - All 14 graduating stipend students achieved scores of 3 or higher on all nine social work competency measures, surpassing the 85% benchmark - CSUF reported mitigating identified challenges w/ stipend disbursement procedure by initiating process early for 2024-2025 academic year

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Double the number of MSW field placements that focus on behavioral health practice with persons from vulnerable communities from 70 to 140 over 5 year grant period.	Number of MSW field placements	70 MSW student placed in first academic year 25 new placement spots added for students within new and existing partner agencies
Award stipends to 108-180 MSW students who fully participate in the CalOptima MSW Stipend Program over 5 year grant period.	Number of students completed the Grant Program	36 stipends were awarded during the academic year 2023-2024; 14 recipients graduated in May 2024
Develop an enhanced curriculum on behavioral health including digital health literacy and telehealth.	Students' clinical competency measured by quantitative and qualitative evaluation methods	Feedback from enhanced curriculum, Simucase, has been overwhelmingly positive, prompting the Social Work Department to integrate Simucase into all MSW advanced practice courses for the 2024-2025 academic year
Offer Career Development Services to all CalOptima MSW Stipend Program students and follow up regarding employment at 1-year post-graduation.	Number of former students with post-graduate employment	-Year 1 Post-graduation employment outcome will be assessed 6 months from graduation; will be reported in the Year 2 semi-annual report (March 2025) -Program exit survey indicated 2 recipients had already accepted job offers within Orange County before their graduation from the MSW program

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/21/2024	**Initiative Name:**	Text Messaging Solutions for members (as part of Virtual Strategy Board Action)	**Start Date:**	7/31/2020
Reporting Period:	Jul-Sep (Q1)			**End Date:**	7/31/2023
Program Status:	Complete	**Initiative Owner:**	Marie Jeannis, RN, MSN, CCM	**Approved Amount:**	$3.9 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Text messaging solutions as part of the overall Virtual Strategy, are intended to strengthen outreach to CalOptima Health members through interactive text messaging services. Purpose of the program is to: (1) Promote wellness and preventive care that include supporting Healthcare Effectiveness Data and Information Set (HEDIS) Measures, (2) Facilitate and encourage healthy behaviors to lead to behavior change, (3) Improve health outcomes, (4) Encourage adherence to recommended care practices.	Developed CalOptima Health mobile texting policy approved by CalOptima Health Board. Standardized text campaign development and launch processes. Grew internal departments use of text campaigns for member outreach. Mobile campaigns developed and launched in all seven threshold languages (English, Spanish, Vietnamese, Farsi, Korean, Chinese, and Arabic) to better serve members language access needs. Initiative completed 7/31/2023. This is the final Impact Summary report.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Communicate COVID-19 vaccine related information to eligible members through text message campaigns.	Number of COVID-19 related text campaigns	Total of 29 campaigns with 4,969,679 texts sent to members in all threshold languages. Topics: (1) Providing information on vaccine safety and effectiveness and the importance of masks, (2) Promoting COH hosted community vaccine clinics, (3) Vaccine gift care program, (4) Information on vaccine boosters.
Expand mobile texting to support HEDIS measures, promote wellness and preventive care. Inform members of COH community events including CalFresh benefits and Medi-Cal Redetermination.	Number of member engagement and community relations texts	2022: 15 campaigns with 944,091 texts sent 2023 (Jan-Jul): 11 campaigns with 475,433 texts sent Campaigns sent in all threshold languages for topics such as cancer screening, well child, flu, and diabetes.
Support CalOptima Health redetermination strategy to meet Department of Health Care Services (DHCS) All Plan Letter 22-004 PHE Unwinding Requirements.	Develop and launch mobile text campaign promoting event.	Developed and launched text message campaign promoting CalOptima Health redetermination event on June 10, 2023. Resulting in 254,599 texts sent.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/8/2024	**Initiative Name:**	Wellness Prevention Program	**Start Date:**	7/1/2024
Reporting Period:	Jul-Sep (Q1)			**End Date:**	6/30/2028
Program Status:	In Progress	**Initiative Owner:**	Carmen Katsarov	**Approved Amount:**	$2.7 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
This project will supplement the Mental Health Service Oversight and Accountability Commission (MHSOAC) funding to support establishment of full clinical operations and prepare Allcove TM South Orange County Youth Drop in Center to create sustainable service streams. Delivery of services will be supported by FTE positions learning opportunities through Stanford CAT.	**Information based on the semi-annual report from June 2024. Next report due Jan 2025. - Sept 2024 CalOptima Health Board approved no cost extension from 6/30/27 to 6/30/28 - Construction designs are completed and in budget. Construction is set to begin January 2025 and interior design will include YAG involvement. - Conditional use permit hearing held August 28th 2024. - Process complete to become licensed Medi-Cal state DHCS provider. - Next steps: 1) Mapping out potential pathways for billing by profession; 2) Explore sustainability through new DHCS multi payer MH fee schedule.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Secure a location for Allcove in South Orange County	Location secured successfully	Secured 10,000 sq ft location for Allcove in South Orange County San Juan Capistrano. Most construction designs completed.
Staff recruitment	Number of hired staff	Hiring 6 new staff members in spring and 10 in the fall of 2024. WPC still in process of finalizing # of total staff needed.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/13/2024	**Initiative Name:**	Comprehensive Community Cancer Screening	**Start Date:**	12/02/2022
Reporting Period:	Jul-Sep (Q1)			**End Date:**	12/31/2027
Program Status:	In Progress	**Initiative Owner:**	Dr. Richard Pitts	**Approved Amount:**	$50.1 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Comprehensive Community Cancer Screening and Support Program aims to create a culture of cancer prevention, early detection and collaboration with partners to work towards a shared goal of dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have equitable access to high quality care.	-Executed 15 grant agreements. -Completed the first round of grant payments. -Initiated discussions on grant oversight and reporting. Next Steps: -Host a grantee kickoff meeting. -Conduct a reporting overview webinar. -Continue other initiative efforts, including research and evaluation.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Increase community and member awareness and engagement	Develop and launch a multimedia, multilingual campaign within the first four years of the program	Worked with Maricich to develop video, radio, and digital ads. Launched the ad campaigns in September 2024 (English, Spanish, and Vietnamese).
Increase access to cancer screening	Develop and implement a community grant initiative by year two of the Cancer Screening and Support program	Executed 15 grant agreements and provided the first round of grant payments.
Increase access to cancer screening	# of COH members to be served	Estimated number of CalOptima Health Members to be served: 969,919.
Improve quality and member experience during cancer screening and treatment procedures	Extend vendor contract(s) to support members through screening, diagnosis and cancer treatment starting in Year 2	DHCS-approved letters for Medi-Cal members (all threshold languages) were translated and will be sent to increase colorectal screenings.
Improve quality and member experience during cancer screening and treatment procedures	Establish contract to evaluate cancer incidence, experiences, and genomic technologies to reduce disparities in late-stage cancer diagnosis by Year 2	TBD

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/21/2024	**Initiative Name:**	COVID-19 Vaccine Member Incentive Program	**Start Date:**	1/7/2021
Reporting Period:	Jul-Sep (Q1)			**End Date:**	12/31/2023
Program Status:	Complete	**Initiative Owner:**	Linda Lee	**Approved Amount:**	$35.6 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
On 1/7/2021, the CalOptima Health Board of Directors approved an incentive program to reward members with $25 gift cards for receiving COVID-19 vaccines in adherence with CDC vaccination recommendations.	The incentive program is completed. The last cohort of members to receive incentives were those members that initiated their COVID-19 vaccination by 4/19/2023. This is the final Impact Summary report.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
CalOptima Health to provide eligible members that are 6 months of age and older a maximum of 4 $25 gift cards (1 gift card per recommended dose). Recommendations based on CDC guidance.	Percent of members with completed COVID-19 vaccinations according to CDC recommended schedule.	CalOptima Health was able to provide a total of 538,744 (58.3%) members with health rewards under the COVID-19 Vaccine Incentive Program that ended on December 31, 2023.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/22/24	**Initiative Name:**	Dyadic Services Program Academy	**Start Date:**	6/1/2024
Reporting Period:	Jul-Sep (Q1)			**End Date:**	5/31/2026
Program Status:	In Progress	**Initiative Owner:**	Carmen Katsarov	**Approved Amount:**	$1.9 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
First 5 Orange County (F5OC) will develop and provide administrative oversight of the CalOptima Health Dyadic Services Program Academy to expand dyadic services capacity. The academy's objective is to increase access to HealthySteps dyadic services for members by launching 10 sustainable dyadic services programs across Orange County. The academy will train 10 clinics to help them understand and utilize the benefit with sustainable results. F5OC will provide pre-academy planning and development, a 9-month academy, and 12-month post-academy technical	- Completed the selection of 10 clinics to participate in the Academy. - Academy started in October 2024. - F5OC is in process of clarifying the support that each clinic needs to successfully complete the academy. - CalOptima Health is developing quantifiable metrics for the program in partnership with F5OC.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Clinics to complete the Academy and obtain HealthySteps certification.	Data from First 5 for clinics that complete the Dyadic Care Training Academy and all required HealthySteps model-specific training and are operating to model fidelity	Academy started Oct 2024 - results are TBD
Increase members receiving well child visits and screenings	Claims/encounter data well child and screenings	To be evaluated later in program
Increase billing for Dyadic Services and non-speciality mental health.	Claims/encounter data Dyadic services and mental health services	To be implemented after academy completion

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/12/2024	**Initiative Name:**	Five-Year Hospital Quality Program	**Start Date:**	1/1/2023
Reporting Period:	Jul-Sep (Q1)			**End Date:**	12/31/2028
Program Status:	In Progress	**Initiative Owner:**	Linda Lee	**Approved Amount:**	$153.5 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Hospital Quality Program for CalOptima Health-contracted hospitals aims to improve quality of care to members through increased quality and patient safety efforts. Program goals: 1) Support hospital quality standards for Orange County; 2) Provide industry benchmarks and data-driven feedback; 3) Recognize hospitals demonstrating quality performance; 4) Provide comparative information on network hospitals; and 5) Identify areas for improvement.	During Q1 FY24/25, CalOptima Health staff gathers performance data from public data sources for each contracted hospital. Data is gathered directly from CMS Hospital Compare and Leapfrog Patient Safety sites. CalOptima Health staff also calculates the total incentive pool accrued and proportion of claims paid for each hospital. This information is used to calculate each hospital's performance on the three hospital quality measures (quality, patient experience, patient safety) and the amount of incentives earned. Staff also creates a performance score card for each hospital.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Reward contracted Medi-Cal hospitals for high performance on hospital quality of care, patient experience, and hospital safety using CMS hospital quality and Leapfrog patient safety measures.	The percentage of contracted hospitals earning hospital quality incentives. Metric equals number of hospitals earning any incentive amount divided by number of eligible contracted hospitals.	Metric to be calculated Q2 FY24/25
	The percentage of hospital quality dollars awarded. Metric equals total incentives awarded divided by total annual incentive pool.	Metric to be calculated Q2 FY24/25
Improve hospital quality	Star Rating	MY2023 average star rating is 3 stars. MY2023 will be established as baseline performance.
Improve hospital patient experience	Star Rating	MY2023 average star rating is 2.6 stars. MY2023 will be established as baseline performance.
Improve hospital patient safety	Safety Grade	MY2023 average safety grade is B. MY2023 will be established as baseline performance.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/21/2024	**Initiative Name:**	Medi-Cal Annual Wellness Visit Initiative	**Start Date:**	07/01/23
Reporting Period:	Jul-Sep (Q1)			**End Date:**	06/30/24
Program Status:	Complete	**Initiative Owner:**	Linda Lee	**Approved Amount:**	$3.8 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Member incentive for CalOptima Health's Medi-Cal only members aged 45 years or older for completion of an Annual Wellness Visit (AWV).	- Member and provider incentives were issued based on completed services and submission of completed, compliant documentation. - Incentives were issued on a rolling basis. - Year to date AWV completed for 30,846 Medi-Cal members. This is the final Impact Summary report.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Increase percent of Medi-Cal members receiving comprehensive annual wellness visits	Number of completed annual wellness visits for Medi-Cal members over 45 years or older	(Apr-Jun) 8,315 YTD: 30,846
Screenings completed with annual wellness visit	Number of SDOH screenings for Medi-Cal members over 45 years or older completed during AWV	(Apr-Jun) 5,609 YTD: 15,351
	Number of breast cancer screenings for Medi-Cal members over 45 years or older completed during AWV	(Apr-Jun) 217 YTD: 564
	Number of cervical cancer screenings for Medi-Cal members over 45 years or older completed during AWV	(Apr-Jun) 210 YTD: 541
	Number of colorectal cancer screenings for Medi-Cal members over 45 years or older completed during AWV	(Apr-Jun) 337 YTD: 855

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	09/11/24	**Initiative Name:**	OneCare Member Health Incentives	**Start Date:**	1/1/2024
Reporting Period:	Jul-Sep (Q1)			**End Date:**	12/31/2024
Program Status:	In Progress	**Initiative Owner:**	Linda Lee	**Approved Amount:**	$500,000
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Provide health rewards and incentives to motivate members to establish primary care relationships and get recommended preventive care and screenings.	-CY 2024 member incentive program:13 member outreach and educational campaigns though 2-way text, newsletters, IVR, direct-mail, and website materials. -Promoted member health incentives at Health Network meetings, flyers, and through bi-monthly quality meetings with Health Network quality staff.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Improve rate of preventive health screenings	Breast cancer screening Colorectal cancer screening Osteoporosis management for people with fractures	58.37% 55.20% 15%
Improve screening rates for members with diabetes	Diabetes care: Blood sugar screening Retinal eye exams	71.73% 57.77%

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	05/07/24	**Initiative Name:**	Post-Acute Infection Prevention Quality Initiate (PIPQI)	**Start Date:**	6/1/2019
Reporting Period:	Jul-Sep (Q1)			**End Date:**	6/01/22
Program Status:	Complete	**Initiative Owner:**	Megan Dankmyer	**Approved Amount:**	$5.3 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
In June 2019, the BOD approved the PIPQI program to prevent infections at contracted Nursing Facilities (NFs) by replacing liquid soap with Chlorhexidine (CHG) soap for bathing and using Iodophor nasal swabs every other week.	- In June 2019, the CalOptima Board of Directors approved $2.3 Million for the program. - In March 2020, the CalOptima Board of Directors approved a separate allocation of $3.4 million in Intergovernmental Transfer (IGT) 9 funds over a three-year period for the expansion of the PIPQI, of which $1 million was allocated for Year 1 and the remaining $2.4 million was allocated for Years 2 and 3 combined. - The program was terminated in 6/2022 due to a lack of outcomes that substantiated continuation. This is the final Impact Summary report.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Reduce the spread of Healthcare Associated Infections (HAI) and Multi-drug resistant organisms MDRO's.	Percentages for HAI and MDROs decreased over 3 years	- The percentages for HAI and MDROs did not decrease over 3 years. - The program did not demonstrate a reduction in infection rates.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/12/2024	**Initiative Name:**	Quality Initiatives from Unearned P4V Program	**Start Date:**	7/1/2024
Reporting Period:	Jul-Sep (Q1)			**End Date:**	12/31/2025
Program Status:	In Progress	**Initiative Owner:**	Linda Lee	**Approved Amount:**	$23.3 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health implements an annual Pay for Value Program (P4V) to promote high quality outcomes and improvement in quality measures among Health Network and CalOptima Health Care Network (CCN) primary care physicians (PCPs). Each year providers earn a portion of allocated incentive dollars and forfeit a portion of incentive dollars by not achieving the highest benchmarks. Starting with the measurement year 2023 P4V program, the Board approved the use of unearned incentive dollars towards quality initiatives.	- Staff created a grant program to solicit improvement proposals and distribute unearned incentive dollars to eligible contracted Health Networks and CCN PCPs. - The Medi-Cal P4V grant program was released on 7/22/2024, a question and answer meeting was held on 8/1/2024, and grant applications were due on 8/23/2024. - CalOptima Health received 82 grant applications. Applications were reviewed by a two-round grant review team. - Approved grants were informed on 9/23/2024 for Health Network applicants. CCN grants are under review.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Stimulate improvement on lower performing quality measures by issuing grants to Health Networks and CCN PCPs for the implementation of quality improvement initiatives	Number of grant awards among Health Networks for Medi-Cal measures	17 grants were awarded to five Health Networks; totaling $3 million.
	Number of grant awards among CCN PCPs for Medi-Cal measures	15 grants were awarded across 12 organizations totaling $2,052,492.
	Number of grant awards among Health Networks for OneCare measures	TBD
Improve quality measures (see attachment)	(attachment)	(attachment)

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
1			CCN		HPN-Regal		OPTUM		Prospect		Family Choice		CHOC		AMVI Care		Noble		AltaMed		UCMG	
2	Clinical Measure (HEDIS)	Submeasure	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile
3	Breast Cancer Screening (BCS-E)	Non-MCR Total	58.47%	67th	58.45%	67th	51.28%	33rd	59.32%	67th	59.58%	67th	0.00%	<10th	66.52%	90th	51.14%	33rd	53.90%	33rd	55.08%	67th
4	Cervical Cancer Screening (CCS)		61.30%	67th	50.75%	10th	53.15%	10th	55.88%	33rd	61.20%	67th	4.31%	<10th	54.54%	33rd	46.03%	10th	57.85%	33rd	53.74%	33rd
5	Child and Adolexcent Well-Care Visits (WCV)	Total	47.07%	33rd	32.35%	<10th	47.69%	33rd	43.45%	10th	53.05%	67th	59.44%	67th	55.25%	67th	46.85%	33rd	41.17%	10th	51.98%	67th
6	Childhood Immunization Status (CIS)	Combo 10	29.60%	33rd	24.16%	10th	27.78%	33rd	41.08%	67th	45.58%	90th	35.64%	67th	34.98%	33rd	32.29%	33rd	41.64%	67th	57.93%	90th
7	Chlamydia Screening in Women (CHL)	Total	72.56%	90th	67.38%	67th	64.16%	67th	67.90%	90th	67.75%	90th	79.93%	90th	83.10%	90th	64.36%	67th	78.93%	90th	64.14%	67th
8	Controlling High Blood Pressure (CBP)		72.43%	90th	57.54%	10th	72.15%	67th	77.12%	90th	69.68%	67th	40.46%	<10th	93.52%	90th	84.12%	90th	82.01%	90th	61.54%	33rd
11	Hemoglobin A1c Control for Patients with Diabete	Poor Control	30.39%	67th	18.14%	90th	34.84%	33rd	37.56%	33rd	47.70%	10th	62.11%	<10th	12.81%	90th	26.50%	90th	27.00%	90th	18.12%	90th
12	Immunizations for Adolescents (IMA)	Combo 2	35.51%	33rd	23.92%	<10th	39.37%	67th	43.24%	67th	47.36%	67th	49.66%	90th	56.27%	90th	45.34%	67th	48.23%	67th	48.74%	67th
13	Lead Screening in Children (LSC)		62.71%	33rd	15.38%	<10th	55.93%	33rd	68.57%	67th	67.89%		64.75%	33rd	64.41%	33rd	64.74%	33rd	78.32%	67th	66.15%	33rd
14	Prenatal and Postpartum Care (PPC)	Postpartum	83.55%	67th	77.82%	33rd	72.62%	10th	53.04%	<10th	70.44%	10th	79.94%	33rd	70.05%	10th	64.63%	<10th	81.20%	67th	74.46%	10th
15	Prenatal and Postpartum Care (PPC)	Prenatal	92.11%	90th	85.63%	33rd	82.22%	33rd	72.54%	<10th	64.20%	<10th	82.96%	33rd	83.58%	33rd	83.50%	33rd	89.23%	67th	58.12%	<10th
16	Well-Child Visits in the First 30 Months of Life (W3	First 15 Months	53.18%	10th	50.00%	10th	60.46%	33rd	67.44%	67th	49.32%	10th	56.50%	33rd	67.02%	67th	57.14%	33rd	64.04%	67th	55.36%	33rd
17	Well-Child Visits in the First 30 Months of Life (W3	15 Months - 30 Months	70.73%	67th	54.55%	<10th	72.26%	67th	74.75%	67th	79.92%	90th	73.13%	67th	68.91%	33rd	71.25%	67th	57.89%	10th	73.86%	67th
18	Satifaction Measure (CAHPS)		Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percetile	Rate	Percetile	Rate	Percentile	Rate	Percentile
19	Adult Care Coordination (Usually + Always)		84.62%	33rd	69.77%	<10th	82.14%	10th	88.89%	67th	80.00%	10th	81.25%	10th	72.73%	<10th	78.57%	10th	83.72%	33rd	71.05%	<10th
20	Adult Customer Service (Usually + Always)		85.71%	10th	83.79%	<10th	92.22%	90th	80.57%	<10th	83.02%	<10th	78.57%	<10th	81.82%	<10th	89.95%	33rd	90.16%	33rd	84.41%	<10th
21	Adult Getting Care Quickly (Usually + Always)		79.62%	33rd	81.79%	33rd	73.12%	<10th	76.94%	10th	72.88%	<10th	73.46%	10th	66.95%	<10th	75.29%	10th	73.95%	10th	73.51%	10th
22	Adult Getting Needed Care (Usually + Always)		80.96%	33rd	80.68%	33rd	75.49%	10th	77.80%	10th	73.13%	<10th	76.42%	10th	67.69%	<10th	81.30%	33rd	81.53%	33rd	72.31%	<10th
23	Adult Rating of Health Care (9+10)		67.71%	90th	55.29%	33rd	40.91%	<10th	44.55%	<10th	53.41%	10th	56.25%	33rd	50.88%	10th	52.54%	10th	63.86%	90th	44.93%	<10th
24	Adult Rating of Health Network (9+10)		59.17%	10th	53.69%	10th	52.08%	<10th	59.56%	33rd	53.08%	10th	68.92%	90th	50.66%	<10th	59.29%	10th	60.84%	33rd	50.61%	<10th
25	Adult Rating of PCP (9+10)		75.81%	90th	63.71%	10th	66.34%	33rd	65.38%	33rd	60.51%	<10th	83.67%	90th	59.62%	<10th	77.33%	90th	68.13%	33rd	64.91%	10th
26	Adult Rating of Specialist (9+10)		62.32%	10th	63.64%	10th	59.26%	<10th	59.74%	<10th	59.04%	<10th	55.56%	<10th	60.38%	<10th	72.73%	90th	76.47%	90th	51.67%	<10th
27	CAHPS Measure		Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percetile	Rate	Percetile	Rate	Percentile	Rate	Percentile
28	Child Care Coordination (Usually + Always)		71.43%	<10th	90.00%	90th	80.77%	10th	78.57%	10th	72.00%	<10th	71.88%	<10th	60.00%	<10th	77.27%	10th	90.48%	90th	70.97%	<10th
29	Child Customer Service (Usually + Always)		86.49%	10th	89.29%	33rd	90.70%	67th	81.62%	<10th	75.00%	<10th	86.27%	10th	78.95%	<10th	89.19%	67th	87.50%	33rd	78.68%	<10th
30	Child Getting Care Quickly (Usually + Always)		75.82%	<10th	90.91%	90th	79.95%	10th	80.22%	10th	81.05%	10th	87.10%	33rd	79.41%	10th	75.75%	<10th	87.50%	33rd	81.46%	10th
31	Child Getting Needed Care (Usually + Always)		72.33%	<10th	78.24%	10th	68.45%	<10th	79.37%	10th	68.14%	<10th	75.70%	10th	71.57%	<10th	74.60%	<10th	84.45%	33rd	68.94%	<10th
32	Child Rating of Health Care (9+10)		50.00%	<10th	50.00%	10th	62.64%	10th	61.11%	<10th	53.85%	<10th	55.13%	<10th	47.62%	<10th	58.90%	<10th	59.68%	<10th	65.42%	10th
33	Child Rating of Health Network (9+10)		55.48%	<10th	59.65%	33rd	67.50%	10th	59.49%	<10th	54.05%	<10th	68.00%	10th	43.44%	<10th	65.66%	10th	68.64%	10th	52.63%	<10th
34	Child Rating of PCP (9+10)		70.69%	10th	63.41%	10th	72.00%	10th	60.95%	<10th	59.35%	<10th	70.34%	<10th	55.13%	<10th	75.00%	33rd	77.78%	33rd	69.74%	<10th
35	Child Rating of Specialist (9+10)		71.43%	33rd	62.50%	10th	77.78%	90th	72.41%	33rd	60.71%	<10th	76.47%	67th	57.89%	<10th	71.43%	33rd	76.92%	67th	52.94%	<10th

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OneCare		CCN		HPN-Regal		OPTUM		Prospect		AMVI Care		Family Choice		AltaMed		Noble		UCMG	
HEDIS Part C Measure	**Submeasure**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**
Breast Cancer Screening (BCS-E)	MCR Total	62.64%	2Star	60.87%	2Star	68.13%	3Star	70.94%	3Star	78.00%	4Star	0.6119	2Star	76.00%	4Star	65.91%	3Star	61.78%	2Star
Colorectal Cancer Screening (COL)	50-75 years old	65.59%	3Star	75.07%	4Star	69.71%	3Star	67.27%	3Star	63.19%	3Star	0.7123	4Star	69.26%	3Star	66.70%	3Star	72.89%	4Star
Eye Exam for Patients with Diabetes (EED)	Total	73.93%	4Star	85.30%	5Star	79.04%	4Star	73.70%	4Star	85.93%	5Star	0.738	4Star	59.59%	2Star	78.57%	4Star	71.68%	3Star
Controlling High Blood Pressure (CBP)		65.84%	2Star	85.61%	5Star	75.68%	4Star	81.53%	4Star	85.40%	5Star	0.6718	2Star	83.20%	5Star	73.79%	3Star	71.72%	3Star
Hemoglobin A1c Control for Patients with Diabetes (HBD)	Poor Control	14.38%	4Star	0.00%	5Star	20.57%	3Star	27.34%	3Star	0.00%	5Star	0.0054	5Star	0.00%	5Star	34.23%	2Star	0.00%	5Star
CAHPS Measure		**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**
Adult Care Coordination (Usually + Always)		86.11%	4Star	89.86%	5Star	87.09%	5Star	87.06%	5Star	83.68%	2Star	87.58%	5Star	86.38%	4Star	86.29%	4Star	86.70%	4Star
Adult Getting Care Quickly (Usually + Always)		74.68%	2Star	75.16%	2Star	78.48%	4Star	74.72%	2Star	74.56%	2Star	76.26%	3Star	74.77%	2Star	72.08%	1Star	78.19%	4Star
Adult Getting Needed Care (Usually + Always)		81.76%	4Star	86.34%	5Star	81.54%	4Star	82.99%	4Star	78.55%	3Star	79.86%	3Star	87.15%	5Star	87.50%	5Star	78.03%	3Star
Part D Measure		**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**	**Rate**	**Percentile**
Medication Adherence for Diabetes Medications (D08)		84.71%	3Star	84.40%	3Star	87.20%	3Star	84.98%	3Star	87.32%	3Star	91.08%	5Star	81.59%	2Star	73.24%	1Star	94.20%	5Star
Medication Adherence for Hypertension (D09)		84.38%	2Star	76.38%	1Star	86.71%	3Star	86.14%	3Star	89.56%	4Star	88.47%	3Star	81.58%	1Star	83.05%	2Star	91.15%	5Star
Medication Adherence for Cholesterol (D10)		83.96%	2Star	82.55%	2Star	82.27%	2Star	83.43%	2Star	83.43%	2Star	86.48%	3Star	79.10%	1Star	79.98%	1Star	86.30%	3Star
Statin Use in Persons with Diabetes (D12)		84.40%	2Star	89.96%	4Star	85.66%	2Star	87.31%	3Star	96.28%	5Star	92.50%	5Star	89.18%	4Star	91.62%	4Star	91.76%	4Star

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/14/2024	**Initiative Name:**	Digital Transformation Strategy	**Start Date:**	2022
Reporting Period:	Jul-Sep (Q1)			**End Date:**	2026
Program Status:	In Progress	**Initiative Owner:**	Yunkyung Kim	**Approved Amount:**	$100.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health has partnered with Accenture to facilitate the implementation of the Digital Transformation Strategy to enhance overall experience for members, providers, and people by bridging technology and business areas, improving member and provider experience, operational effectiveness, and financial performance.	- 3 projects started and completed on time and within budget: NICE Contact Center telephony system, Member and Provider Digital Engagement Strategy, and Claims Robotic Process Automation. - Over 200 Customer Service Reps went live on the NICE Contact Center telephony system on November 14, 2024. - Salesforce Call Center CRM and Microsoft Dynamics Finance projects initiated in October 2024. - The Salesforce Provider Lifecycle Management project has completed the infrastructure build for the integration "hub" of the core systems and is halfway through the development phase. ADP is on track to go live in December 2024.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Improve Member & Provider Experience by providing an improved digital experience	% of completion of member and provider requests through self service digital tools	TBD - metrics development in progress
Complete Digital Transformation projects on-time and within budget	95% of projects delivered on-time and within budget	100% (3 out of 3 active) projects completed on time and within budget - NICE Contact Center telephony system - Budget: $2,133,000 - Member and Provider Digital Engagement Strategy - Budget: $250,000 - Claims Robotic Process Automation - Budget: $1,500,000

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/12/2024	**Initiative Name:**	Medi-Cal Provider Rate Increases	**Start Date:**	7/1/2024
Reporting Period:	Jul-Sep (Q1)			**End Date:**	12/31/2026
Program Status:	In Progress	**Initiative Owner:**	Yunkyung Kim	**Approved Amount:**	$526.2 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Authorize the CEO to execute amendments to delegated Health Networks and specific CalOptima Health Medi-Cal FFS CCN/COD contracts that update contracted rates, effective 7/1/2024, and incorporate requirements to comply with DHCS mandated Targeted Rate Increases (TRI) and other regulatory and operational requirements, effective 1/1/2024. This initiative aims to improve quality outcomes through increased access, increased provider and member satisfaction (i.e. CAHPS measures), and decreased provider terminations due to non-market competitive rates.	1) Executed contracted amendments to implement rate increases. 2) Developed tracking reports for network additions and terminations. 3) Presented provider quality overview and baseline scores at the Q3 Quality Assurance of the Board.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Maintain and increase members' access to care.	Maintain and enhance network adequacy.	1) Added a provider network summary to CalOptima Health Fast Facts published monthly in the CalOptima Health Board Book. 2) Presented network adequacy deficiencies at the Q3 Quality Assurance Committee of the Board.
	Increase timely access to care for members.	Presented 2023 Timely Access Survey at the Q3 Quality Assurance Committee of the Board.
Maintain and increase quality of care for members.	Increase quality scores through the 2024 HEDIS and Quality Scores.	TBD: 2024 HEDIS and quality scores to be released in Q3, 2025.
Improve provider satisfaction.	Increase provider satisfaction scores.	Provider survey is being fielded in Q3 and Q4.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	11/15/2024	**Initiative Name:**	Skilled Nursing Facility Access Program	**Start Date:**	1/1/2023
Reporting Period:	Jul-Sep (Q1)			**End Date:**	12/31/2026
Program Status:	In Progress	**Initiative Owner:**	Dr. Zeinab Dabbah	**Approved Amount:**	$10.0 Million
Payment Status:	Not Started				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Skilled Nursing Facility (SNF) Access Program is to enhance quality through better access and further strengthen the safety net system across Orange County for individuals who require SNF post-hospitalization care.	- Identified 4 categories of difficult to place members and provided additional incentives for accepting members. - Next steps: 1) Implement clinical SNF rounds 2) Create a preferred SNF network 3) Partner with dialysis provider (Fresinius) for mobile units - No funds have been utilized at this time; continuing to identify opportunities to expand on program requiring resource support.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Improve acceptance rate for TOC patients from acute setting to SNF	Reduced administrative days by 5%	In development; data analysis in progress
Establish clinical rounds at SNFs by Q2 2025 (CY)	Established clinical rounds with SNF providers	Established clinical rounds at 3 largest identified SNF providers
Establish partnership meetings with contracted SNFs	Established partnership meetings	First meeting held in Aug 2024 with 60 participants; future meetings are being planned
Improve provider payments for difficult-to-place members	Rate enhancement for members w/ isolation, bedside dialysis, social and behavioral obesity	Implemented; enhanced rates effective July 2024 through Medi-Cal Provider Rate Increase

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

14. Authorize the Chief Executive Officer to Execute Contract Amendments with Collective Medical Technologies, Inc., a PointClickCare company, and Safety Net Connect, Inc. to Improve Information Exchange for Members and Providers Across Care Settings

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Kelly Giardina, Executive Director, Clinical Operations, (714) 745-0125

Recommended Actions

1. Make an exception to CalOptima Health Policy GA.5002: Purchasing Policy and authorize the Chief Executive Officer to execute a contract amendment without competitive procurement with Collective Medical Technologies, Inc., a PointClickCare company, to:
    a. Expand the scope of work to include new products for the Medicare line of business;
    b. Update payments terms; and
    c. Extend the contract term for an additional three-year term beginning November 30, 2025, with two one-year extension options, each exercisable at CalOptima Health's discretion.

2. Make an exception to CalOptima Health Policy GA.5002: Purchasing Policy and authorize the Chief Executive Officer to execute a contract amendment without competitive procurement with Safety Net Connect, Inc., to:
    a. Extend the contract for a three-year term beginning December 17, 2025, with two one-year extension options, each exercisable at CalOptima Health's discretion under the same terms and conditions.

Background

Collective Medical Technologies, Inc., a PointClickCare company (Collective Medical Technologies) is one of CalOptima Health's hospital data exchange services, providing real-time or near real-time information and alerts on members' emergency department (ED) visits, hospital admissions, transitions of care, and referrals to community-based organizations. Collective Medical Technologies acute-care encounter data allows CalOptima Health to meet regulatory requirements for transition of care services by ensuring timely admission, discharge, and transfer (ADT) notifications from acute care facilities, EDs, and skilled nursing facilities (SNFs), as required in the Department of Health Care Services (DHCS) 2024 Population Health Management Policy Guide.

Safety Net Connect, Inc. (SNC) provides CalOptima Health with hospital data exchange services and a service portal (CalOptima Connect) to support CalOptima Health's CalAIM program. Community Supports and Enhanced Care Management (ECM) providers leverage the system to manage service referrals, authorizations, and provider invoice billing for the CalAIM program. As CalAIM continues to evolve with additional service offerings, SNC has added critical new components and provided enhancements to its system to support the changes needed to enable providers to serve CalOptima Health's members. This CalAIM service portal data currently integrates with Jiva, CalOptima Health's clinical documentation platform for utilization, authorization, automation and care plan completion.

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In November 2020, CalOptima Health executed contracts with Collective Medical Technologies and SNC after completion of a formal competitive procurement process for the most comprehensive information exchange solution. The Collective Medical Technologies initial contract effective date was November 30, 2020, with an end date of November 29, 2025. The SNC initial contract effective date was December 17, 2020, with an end date of December 16, 2025.

Although there are similarities in the services that Collective Medical Technologies and SNC provide, the unique and extensive programmatic design for each vendor delivers separate solutions to providers at the point of service.

Discussion

Collective Medical Technologies Contract Amendment

Shortly after signing the contract, Collective Medical Technologies was acquired by PointClickCare Technologies, Inc. (PointClickCare). Staff was informed that new products were available to CalOptima Health that were not previously available at the time of the initial contract.

PointClickCare expanded the post-acute data set that was combined with Collective Medical Technologies' full-continuum network, giving CalOptima Health and delegated health networks real-time access to clinical information during a member's inpatient episode. This expanded access to data has significantly improved care coordination, member follow-ups, and clinical outcomes by sharing vital and timely information from CalOptima Health's contracted and non-contracted hospitals. This integrated and seamless data sharing allows for enhanced collaboration and care delivery between health plans and providers.

CalOptima Health Policy GA.5002: Purchasing outlines the processes for the 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, or other circumstances 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 (Board) authorize an exception to CalOptima Health Policy GA.5002: Purchasing to expand the scope of work to include new products for the Medicare line of business, update payment terms, and extend the contract term with the existing vendor without competitive procurement.

Staff recommends expanding the scope of work effective November 30, 2024, to include three new services that will strengthen current data integration with hospitals, SNFs, and clinical teams coordinating care within the OneCare program. These services will enhance current OneCare data sharing and care coordination as follows:

- PACMan for Health Plans - Connects hospitals and health systems/managed care plans with post-acute partners (*e.g.*, SNFs, Long-Term Acute Care) through real-time insights.

- Quality & Coding Management (QCM) - Provides visibility into member care needs and coding gaps to help improve collaboration and timely intervention and optimize quality and performance metrics (*e.g.,* Centers for Medicare & Medicaid Services Star Ratings).

- QCM with Transition of Care - Queries Collective Medical Technologies' network hospitals and returns acute discharge information from continuity-of-care documents. This information can then be utilized by attributed providers and health systems/managed care plans for more coordinated care delivery.

Effective November 30, 2025, the new contract will update payment terms to include Consumer Price Index for All Urban Consumers (CPI-U) increases. CPI-U is a measure of inflation that tracks the average change in prices paid for services consumed by urban households. Incorporating a CPI-U increase will address the effects of inflation during the contract period.

Staff recommends that the Board authorize an exception to CalOptima Health Policy GA.5002: Purchasing to allow CalOptima Health to renew its existing contract with Collective Medical Technologies beginning November 30, 2025, for an additional three-year term with two additional one-year extension options, each exercisable at CalOptima Health's discretion, without competitive bidding.

Collective Medical Technologies is an industry-leading healthcare software provider with a robust network and exceptional coverage of Orange County-based hospitals and SNFs. This service enables CalOptima Health's contracted and non-contracted facilities to provide timely notification of ADT, ensuring members receive the necessary care. CalOptima Health is currently unaware of other vendors with comparable SNF and ADT volume. Although there are companies offering similar services, they are not centered in Orange County. When the solicitation for proposals was completed in November 2020, two proposals were found to be suitable, Collective Medical Technologies and SNC, and CalOptima awarded both companies contracts. Replicating the network and the procurement process would require a significant investment of time, money, and resources; delay clinical operations; and may result in regulatory non-compliance. Staff estimates it would take up to two years to select a new contractor and develop a comparable network.

Attachment 2 provides a summary of the new product services, including additional features, events of interest, and types of scheduled reports, that will be included in the expanded statement of work. Attachment 3 provides additional details on the new products' subscription fee and program configurations.

SNC Contract Amendment

Staff recommends that the Board authorize an exception to CalOptima Health Policy GA.5002: Purchasing to allow CalOptima Health to extend its existing contract, under the same terms and conditions, with SNC beginning December 17, 2025, for an additional three-year term with two additional one-year extension options, each exercisable at CalOptima Health's discretion, without competitive bidding.

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SNC has demonstrated agility and partnership with CalOptima Health to create CalOptima Connect. CalOptima Connect is an integrated referral and authorization module that connects Community Supports providers to clinical inpatient information for real-time coordination of care. The initial speed to build allowed for the launch of 14 Community Supports programs, two ancillary programs (Supplemental Housing Assistance and Community Health Workers), and all nine ECM Populations of Focus. SNC has been agile in creating additional program enhancements in their system to support each initiative and address changes from DHCS.

Replicating and building access to a new CalAIM provider network would require significant expenses, delays, and potential regulatory non-compliance. The extensive configuration needed to connect the data exchange between SNC and CalOptima Health technology platforms would result in unmanageable and non-compliant delays to payment and clinical operations.

It is important to maintain consistency and streamlined protocols for CalAIM providers to continue to operationalize the DHCS's vision for ECM and integrated Community Supports.

Fiscal Impact

Collective Medical Technologies, a PointClickCare company Contract Amendment

The estimated annual net fiscal impact to expand the scope of work to include new products for the Medicare line of business is $54,000, or $31,500 for the seven-month period of November 30, 2024, through June 30, 2025 in the current fiscal year. Funding for the new products will be funded within the Medical Management budget approved in the CalOptima Health FY 2024-25 Operating Budget on June 6, 2024.

Effective November 30, 2025, the estimated annual net fiscal impact to account for the new products for the Medicare line of business and the CPI-U increases is approximately $370,000. The total annual cost for the Collective Medical Technologies contract is approximately $1.5 million. Staff will include operating expenses for the period beginning July 1, 2025, and after in future operating budgets.

SNC Contract Amendment

The total annual cost for SNC contract is approximately $1.6 million. Staff will include operating expenses for the period beginning December 17, 2025, and after in future operating budgets.

Rationale for Recommendation

Approving the contract extensions with Collective Medical Technologies will ensure continued access to hospital and SNF ADT data exchange services, enabling real-time transmission of members' ADT data for clinical decision-making, data sharing, and regulatory compliance. In addition, funding new product services for Medicare members will enhance member activity visibility and care management support.

Approving the contract extension with SNC will ensure continued access to CalOptima Health's Community Supports providers to support the CalAIM program. The collaboration and data sharing on

the CalOptima Connect portal hosted by SNC enables CalOptima Health's providers to continue their outreach to the vulnerable homeless population.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Covered Entities
2. Product Services Summary

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Collective Medical Technologies, a PointClickCare company	4760 S. Highland Dr. Suite 217	Holladay	UT	84117
Safety Net Connect	101 Academy Way Suite 100	Irvine	CA	92617

Attachment 1 to the December 5, 2024 Board of Directors Meeting – Agenda Item 14

New Product Services Summary

	PACMan for Health Plans (SNF)	**Quality & Coding Management (QCM)**	***QCM with Transition of Care (TRC)**
Feature Pages (Portal)	Patient overview Cohorts Scheduled Reports Notifications Manage Facility (e.g., manage users)	Patient overview Cohorts Scheduled Reports Notifications Manage Facility (e.g., manage users)	CMT will query Collective Medical network hospitals and return acute discharge information from Continuity of Care Documents (CCDs) which can then be delivered to attributed providers and Subscribers. <u>Delivery to Subscriber:</u> • CCD feature in Subscriber portal • Share Acute Discharge Summary Key Components • Monthly report outlining various encounter elements <u>Delivery to Attributed Care Provider:</u> • CMT will collaborate with Subscriber to make acute CCDs available to attributed care providers within 48 hours from the date of discharge through Collective Medical Portal or Direct Secure Email **TRC product service is only available if the QCM product service is purchased – cannot be a stand-alone product service*
Additional Features (Portal)	Patient Search Patient Demographic Tags Care Team Encounter Information Care Insights Security & Safety Events Customer Community (Help) EMR data for case management including demographics, functional independence, patient clinical information including temperature, heart rate, blood pressure, respiratory rate, oxygen saturation, blood glucose, pain, weight, diagnoses, and active medications.	Patient Search Patient Demographic Tags Care Team Encounter Information Care Insights Security & Safety Events Customer Community (Help)	
Events of Interest (Criteria)	SNF Admissions SNF Discharges ED Encounter Post SNF Discharge 30 days IP Admission Post SNF Discharge 30 days Tag/Flag Criteria	Acute Care Encounters Categorized Encounters Tag/Flag Criteria	
Scheduled Reports (Can be delivered daily, weekly, or monthly)	• Patient Activity (Census Reports) – all patient SNF encounters in specific timeframe • Criteria (Cohort) Resorts – patient who met specific criteria in a timeframe • Flag Reports – patient lists related to specific Flags sourced • New Member Utilization Reports – historical utilization for new health plans members	• Criteria (Cohort) Resorts – patient who met specific criteria in a timeframe • Flag Reports – patient lists related to specific Flags sourced • New Member Utilization Reports – historical utilization for new health plans members	

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
15. Approve Actions Related to CalOptima Health Policy AA.1400: Grant Management

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Donna Laverdiere, Executive Director of Strategic Development, 714-986-6981

Recommended Actions
Approve the revised CalOptima Health Policy AA.1400: Grant Management, effective December 6, 2024.

Background
On May 4, 2023, the CalOptima Health Board of Directors (Board) adopted CalOptima Health Policy AA.1400: Grant Management to provide guidance on grant management processes related to CalOptima Health's community investments and the impact of those grants.

On October 5, 2023, the Board approved a contract amendment with Ankura Consulting Group, LLC (Ankura) to provide professional services for regulatory and contractual compliance of external grants and other internal Board-approved initiatives. Ankura conducted interviews with CalOptima Health staff regarding the grants management process and reviewed relevant documentation. After the completion of the end-to-end assessment, Ankura provided CalOptima Health leadership with a report of their observations and identified areas for improvement. The recommendations included updating the internal policy and developing a standardized process document to ensure consistent and efficient program management across business owners and program types. CalOptima Health staff have implemented both recommendations.

Discussion
CalOptima Health Staff has updated Policy AA.1400: Grant Management to standardize and document improvements in grant management processes. The revised policy provides greater clarity on the procedures for each step in the grant award and management cycle and creates alignment in the overall grant program management and oversight within CalOptima Health. The proposed changes from the current version include:

- Clarification of terminology, definitions, and references;
- Additional policies and procedures in the following topic areas:
  - Ethics;
  - Grant funding approvals;
  - Grant funding opportunity documentation;
  - Grant application and evaluation processes;
  - Grant agreements and reporting requirements;
  - Grant funding disbursements;
  - Grant modifications;
  - Grant close-out and audits; and

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- Other non-substantive changes (*i.e.*, formatting, spelling, punctuation, capitalization, minor clarifying language, and/or grammatical changes).

CalOptima Health staff, with the assistance of outside general legal counsel, reviewed and revised the policy to ensure its provisions align with federal and state statutory and regulatory requirements. CalOptima Health staff seeks Board approval for the revised version of the policy, effective December 5, 2024.

Fiscal Impact
The recommended action has no additional fiscal impact.

Rationale for Recommendation
The revised CalOptima Health Policy AA.1400: Grant Management will provide greater assurance that CalOptima Health grant funds are being spent appropriately and that an effective grant administration process is in place to ensure regulatory and contractual compliance within CalOptima Health's operations.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Previous Board Action May 4, 2023 "Approve New CalOptima Health Policy AA.1400p: Grant Management
2. Revised CalOptima Health Policy AA.1400: Grant Management

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken May 4, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
10. Approve New CalOptima Health Policy AA.1400p: Grant Management

Contacts
Peter Bastone, Chief Strategy Officer, (714) 246-8459
Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, (714) 954-2140

Recommended Actions
Approve new CalOptima Health Policy AA.1400p: Grant Management.

Background/Discussion
Over the past several years, CalOptima Health has made significant investment in the community through grant awards, made possible by Board-directed reserves and incentive funds. While the impact of these investments has been significant for members and the Orange County community, staff would like to codify the process around goal setting, metric development, and monitoring for grant agreements.

Through programs like the Department of Health Care Services Housing and Homelessness Incentive Program (HHIP), CalOptima Health has been, and will continue to be, the recipient of significant financial incentives that are intended to flow into the community, working to address regional health and social issues. Between the HHIP program and other revenue streams, it is anticipated that CalOptima Health will continue to award community grants over the next several years. In order to adequately steward these funds, staff have developed a policy that ensures all grant funding is tied to relevant program goals, measurable metrics that capture program impact and success, and a monitoring process to review progress toward these objectives. While staff have already been implementing these processes, CalOptima Health has not adopted a formal policy.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation
CalOptima Health staff recommends that the Board approve and adopt policy AA.1400p: Grants Management to ensure CalOptima Health can effectively distribute and monitor community investments and the impact of those grant awards.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. New CalOptima Health Policy AA.1400p: Grant Management

/s/ Michael Hunn *04/26/2023*
Authorized Signature **Date**

Policy:	AA.1400p
Title:	**Grant Management**
Department:	Strategic Development
Section:	N/A
CEO Approval:	
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines the criteria and expectations to ensure consistency and accountability in managing discretionary Grant funding disbursed by CalOptima Health.

II. POLICY

A. Approach

1. When resources permit, CalOptima Health may designate authorized funds specifically for CalOptima Health Board of Directors (hereinafter, 'Board')-approved Grants to eligible external organizations with the goal of improving the health of CalOptima Health's Members.

2. CalOptima Health shall ensure the distribution of Grant funds is reflective of CalOptima Health's mission, consistent with CalOptima Health's Strategic Plan, any Board-approved fund allocation plan, and/or any funding source legal parameters and funding restrictions. CalOptima Health shall uphold the following tenets when awarding Grants:

   a. CalOptima Health shall consider Proposals from external organizations that provide services for programs or projects aligned with CalOptima Health's mission, Strategic Plan, and/or any Board-approved fund allocation plan and directly serve CalOptima Health Members.

   b. Each Grant application shall receive a thorough, unbiased evaluation and review including an assessment of organizational experience, capacity, fiscal soundness, alignment with CalOptima Health's mission, Strategic Plan, and/or Board-approved fund allocation plan, demonstrated need, benefit to CalOptima Health Members, and feasibility.

   c. CalOptima Health shall strive for timely application approval and payment of award and shall regularly evaluate the application process to identify areas for greater efficiency.

   d. Reporting requirements for Grant awards shall align with section III.B. of this policy and shall be commensurate with the amount of funds being awarded and with the nature of the funding opportunity.

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III. PROCEDURE

A. Pre-Award Assessment:

1. Grant objectives shall be in alignment with organizational strategic priorities.

2. Grant outcomes shall improve or address critical needs of CalOptima Health Members.

B. Award Grant: Establishing Goals and Metrics

1. CalOptima Health will work with Grantees to ensure that all Grants have established one or more goals that direct the use of Grant funds.

2. CalOptima Health will work with all Grantees to ensure that Grants align with one or more metrics signifying the successful accomplishment of its goal or goals. These metrics will be the basis for monitoring and reporting outcomes and successes.

C. Post-Award: Grant Monitoring and Reporting Requirements

1. CalOptima Health Operations department and/or other internal subject matter experts shall monitor a Grantee's compliance and progress towards achieving the goals presented in the Grantee's Proposal by reviewing the Grant Progress Reports.

   a. Unless otherwise specified in the Grant contract, Grantees shall submit semi-annual Grant Progress Reports, detailing Grant activities, along with any required supporting materials.

      i. The format and specific details of the Grant Progress Report shall be mutually agreed upon by CalOptima Health and the Grantee.

   b. The semi-annual Grant Progress Reports may require a breakdown of funding utilization by category as mutually agreed upon by CalOptima Health and the Grantee.

2. CalOptima Health may also utilize Grant Progress Reports to provide updates to CalOptima Health's executives and the CalOptima Health Board about its Grant funding activities.

3. Grantees shall also submit a final closeout report as stipulated in the Grant contract, summarizing the actions taken by the Grantee over the course of the entire Grant contract term.

   a. The final closeout report will include a breakdown by category of the funds used, and a reconciliation to indicate all funds were used according to the intended purpose.

4. As part of CalOptima Health's due diligence, CalOptima Health's designated representative(s) may also elect to conduct site visits to a Grantee's business premises and/or site(s) of Grant-funded service delivery during the Grant contract term for the following actions including, but not limited to:

   a. Meet the Grantee's senior leadership, as well as the Grantee's staff or volunteers with primary responsibility for conducting the funded activities;

   b. Engage in dialogue with the Grantee about progress toward project milestones and objectives, notable successes, implementation challenges, and early lessons learned;

   c. Learn of any anticipated requests for scope or budget changes, or no-cost extensions; and

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d. See program services/activities first-hand, if applicable and feasible.

5. Grant payments may be delayed or withheld if site visits and/or Grant Progress Reports reveal Grantees are not making sufficient progress towards stated goals or are not meeting other Grant contract requirements.

   a. If sufficient progress is not being made toward Grant contract goals and metrics, CalOptima Health will work with Grantees to understand why metrics were not achieved and work with the Grantee to realign metrics if deemed appropriate.

6. CalOptima Health may conduct audits of the Grantee and/or of the related CalOptima Health operational areas and financial data during the course of the Grant and/or at the conclusion of the Grant.

   a. The audits will be conducted to confirm reported expenditures, performance measures, compliance with key Grant requirements, and other relevant factors as applicable to the specific Grant.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Strategic Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

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		AA.1400p	Grant Management	Administrative

IX. GLOSSARY

Term	Definition
Grantee	A recipient of a grant.
Grants	A financial award given by CalOptima Health to an eligible recipient to achieve a particular purpose or project. Grants are generally not expected to be repaid by the recipient when appropriately used for an approved grant project.
Member	A beneficiary enrolled in a CalOptima Health program.
Proposal	An application submitted to CalOptima Health used to formally request funding for a specific project.
Strategic Plan	CalOptima Health's strategic priorities, objectives, and action plans.

Policy:	AA.1400
Title:	**Grant Management**
Department:	Strategic Development
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	05/04/2023
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines the criteria for awarding Grant funds and the expectations ~~to ensure consistency and accountability in managing~~of Grantees for discretionary Grant funding disbursed by CalOptima Health.

II. POLICY

A. Ethics

1. General Conduct

a. Each Covered Person is subject to the Conflict of Interest Laws of the State of California (State) and the CalOptima Health Code of Conduct. Any Covered Person who violates these standards will be subject to the relevant penalties, sanctions, and other disciplinary actions.

2. Gratuities, Kickbacks, and Contingency Fees

a. Except as allowed under CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments, no Covered Person may solicit or accept any personal gift or anything of value from any person or entity to which a Grant is under consideration for award, has been awarded, or may be awarded, or because of any action taken or to be taken in the performance of the Covered Person's duties. Any Covered Person failing to adhere to the above will be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, up to and including dismissal.

b. CalOptima Health employees must adhere to all provisions of CalOptima Health Policies AA.1204: Gift, Honoraria, and Travel Payments, and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health.

3. Confidential Information

a. No Covered Person may use Confidential Information, or information regarding a Grant that has not been made public or become subject to the California Public Records Act, for their actual or anticipated personal gain, or the actual or anticipated personal gain of any other person related to such Covered Person by blood, marriage, or by common commercial

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or financial interest. A Covered Person failing to adhere to this requirement will be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, up to and including dismissal.

b. No Covered Person may divulge Confidential Information to any Grantee, vendor, consultant, or contractor outside the scope of any agreement that may exist with the Grantee, vendor, consultant, or contractor.

c. While a Notice of Funding Opportunity (NOFO) is active, to prevent unfair and inequitable treatment of applicants, no Covered Person may discuss the strengths and weaknesses of an applicant with any other applicants.

4. Personal Conflict of Interest

a. No Covered Person may participate in the selection, award, or administration of an agreement with a Grantee, or in any decision that may have a foreseeable impact on a Grantee if a conflict of interest, real or apparent, exists. Such a conflict arises when a Covered Person, or a Covered Person's spouse, children, or domestic or business partner, has an existing relationship with the applicant, is employed by or has received an offer of employment from the applicant, or is in a position to influence a decision that may result in personal or financial gain to the Covered Person or the Covered Person's spouse, children, or domestic or business partner, as a result of the Grantee's selection or award.

5. Organizational Conflict of Interest

a. Organizational conflicts of interest are circumstances that arise out of a party's business or financial interests, familial relationships, contractual relationships, organizational structure, or existing or past activities, including any prior interactions or work with CalOptima Health, that result or can result in influence on requirements, such as unreleased budgets, scopes of work, selection criteria, or unequal access to information, or the appearance or reality of impropriety or unfair advantage to the party.

b. No person or entity may submit a Grant application if the person or entity has:

i. Directly assisted in drafting or in preparing the specifications, requirements, or cost estimates for that Grant; or

ii. Had access and exposure to information pertinent to that Grant that was unavailable to other potential applicants and would provide a competitive advantage to its possessor.

~~A.~~B. Approach to Grant Management

1. When resources permit, CalOptima Health may designate authorized funds specifically for ~~CalOptima Health Board of Directors (hereinafter, 'Board')~~ Board-approved ~~Grants~~Grant(s) to eligible external organizations ~~with the goal of improving the health of CalOptima Health's Members.~~ .

2. CalOptima Health ~~shall~~will ensure the distribution of Grant funds is reflective of CalOptima Health's mission, consistent with CalOptima Health's Strategic Plan, any Board-approved fund allocation plan, and/or any funding source legal parameters and funding restrictions. ~~CalOptima Health shall uphold the following tenets when awarding Grants:~~

a. CalOptima Health shall consider Proposals from external organizations that provide services for programs or projects aligned with CalOptima Health's mission, Strategic Plan, and/or any Board-approved fund allocation plan and directly serve CalOptima Health Members.

3. Each Grant application shallApplication will receive a thorough, unbiased evaluation and review including, but not limited to, an assessment of organizationalan organization's experience, capacity, fiscal soundness, alignment with CalOptima Health's mission, Strategic Plan, and/or Board-approved fund allocation plan, demonstrated need, benefit to CalOptima Health Members, and feasibility.

b. CalOptima Health shall strive for timely application approval and payment of award and shall regularly evaluate the application process to identify areas for greater efficiency.

c. Reporting requirements for Grant awards shall align with section III.B. of this policy and shall be commensurate with the amount of funds being awarded and with the nature of the funding opportunity.

C. Approvals

1. Funding and funding reallocation for all Grant Awards will be approved by the Board through separate Board actions.

D. Grant Award Funds

1. Grant Award fund disbursements may only be approved by an authorized person pursuant to CalOptima Health's Policy GA.5002: Purchasing.

2. Any person in a position of delegated authority may designate a person of the same level or higher, in writing, to act in their stead when that person is unavailable.

3. Grant fund disbursement approval limits will be consistent with CalOptima Health's Policy GA.5002: Purchasing:

Employee Position	Approval Limit
Manager	$ 1,000
Director	$ 10,000
Executive Director or Officer	$ 100,000
CEO or Chief Operating Officer (COO)	$ Over 100,000

III. PROCEDURE

A. Pre-Award Assessment:

A. : Grant Authorization Requirements

1. Grants Management will coordinate program development and provide guidance on the grant-making process to initiative owners and/or Sponsoring Department as appropriate.

2. The Sponsoring Department will develop the requirements and criteria for the specific Grant.

3. The Sponsoring Department will develop a NOFO that outlines specific information about the Grant program. Refer to Section III.B. for NOFO requirements.

4. The Sponsoring Department will complete a CalOptima Health Board Action Agenda Referral (COBAR) for Board authorization of the Grant program.

B. Notice of Funding Opportunity (NOFO) Requirements

1. CalOptima Health will issue a NOFO for all Grant programs.

2. At a minimum, each NOFO will contain the following elements:

a. The title of the Grant program;

b. Goals and objectives ~~shall~~of the Grant program;

c. The Grant availability period;

d. Key Dates, particularly due dates for questions and submission of applications;

e. Total Grant program amount;

f. The minimum and maximum amount of each Grant, if applicable;

g. Specific eligibility requirements;

h. Evaluation criteria;

i. Instructions on submitting applications; and

j. CalOptima Health contact information and communication protocols.

3. CalOptima Health will post the NOFO on its website.

C. Pre-Award: Application Process

1. Upon Board approval of the Grant, CalOptima Health will develop an electronic Grant Application.

2. The electronic Grant Application will be published in ~~alignment with~~the Grants Management system.

3. CalOptima Health may hold a webinar and will publish a frequently asked questions document about the funding opportunity during the application period.

4. Grant Applications will not be accepted after the application period closes.

D. Pre-Award: Grant Application Evaluation and Selection

1. CalOptima Health will select an Evaluation Committee for each NOFO consisting of CalOptima Health employees and, if needed, outside subject matter experts (SMEs).

2. Prior to receiving applications, Grants Management will identify the applicants to each member of the Evaluation Committee. Any person who has a conflict of interest, must inform Grants Management in writing and recuse themselves from further participation in the evaluation

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process. All persons given access to Grant Applications must document a confidentiality and conflict of interest statement.

3. Grant Applications will first be reviewed for eligibility. Applications that are ineligible will be rejected.

4. The Evaluation Committee will evaluate each Grant Application against the evaluation criteria established in the NOFO.

5. The Evaluation Committee will proceed as follows:

   a. Review each Grant Application and score each application based on the Evaluation Criteria published in the NOFO;

   b. Meet one or more times to discuss their evaluation results during the evaluation period; and

   c. Recommend applicants for Grant Awards based on their scores and funding availability for Board approval.

   ~~a.~~d. An organizational ~~strategic priorities.~~ financial review will be conducted for all or a subset of grant applicants to assess financial solvency.

~~2.~~6. Grant ~~outcomes shall improve or address critical needs of~~ Award recommendations will be submitted for review and approval to the CalOptima Health ~~Members~~Board.

~~Award Grant~~

7. Upon Board approval of one or more Grants, Grant Management will:

   a. Send written notification of their application status to all Grant applicants.

   b. Offer feedback to non-selected applicants if requested.

~~B.~~E. Grant Award: Establishing ~~Goals and Metrics~~Measurable Objectives and Agreement Execution

1. CalOptima Health will ~~work with Grantees to~~ ensure that all Grants have established one or more ~~goals that direct the use of Grant funds~~performance objectives that are measurable and documented in the Grant Agreement. These performance objectives will be the basis for Grant monitoring and reporting.

~~1. CalOptima Health will work with all Grantees to ensure that Grants align with one or more metrics signifying the successful accomplishment of its goal or goals. These metrics will be the basis for monitoring and reporting outcomes and successes.~~

2. CalOptima Health will provide a formal Grant Award letter to the selected Grantee, including applicable templates for Progress Reports, a scope of work, and a Grant payment schedule.

3. Once the necessary documents, including certificate of insurance are obtained, a Grant Agreement will be executed between CalOptima Health and the Grantee.

   a. The Grant Agreement will be sent electronically to the Grantee's point of contact. The document must be signed by an individual who has the authority to legally bind the Grant(s) (Official Signatory).

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b. The Grantee will be given a sufficient number of days to review the Grant Agreement. CalOptima Health will work with the Grantee to finalize the Grant Agreement.

F. Post-Award: Payment of Grant Fund Disbursements

1. Upon receipt of the fully executed Grant Agreement, CalOptima Health will process payments according to the established payment schedule.

2. CalOptima Health will review Progress Reports, invoices, receipts, and other documentation to determine whether adequate progress has been achieved and that Grant fund expenditures are appropriate before releasing subsequent Grant fund disbursements.

3. Upon completion of the Grant program and closeout review, CalOptima Health will obtain any funds that are found to not have been utilized in accordance with the Grant Agreement.

~~C.~~G. Post-Award: Grant Performance Monitoring and Reporting Requirements

1. CalOptima Health ~~Operations department~~will review Progress Reports and~~/or other internal subject matter experts shall~~ request meetings as needed to monitor ~~a Grantee's~~ compliance and progress towards achieving the ~~goals presented~~objectives in the ~~Grantee's Proposal by reviewing the~~ Grant ~~Progress Reports.~~ Agreement.

~~2.1.~~~~Unless otherwise specified in the Grant contract, Grantees shall~~The Grantee will submit ~~semi-annual Grant~~ Progress Reports based on schedule and frequency indicated in the Grant Agreement to CalOptima Health, detailing ~~Grant~~Grantee activities, along with any required supporting materials through the submission method~~.~~

~~3.~~2. ~~The format and specific details of the Grant Progress Report shall be mutually~~ agreed upon by Grantee and CalOptima Health ~~and the Grantee~~Sponsoring Department.

~~4.~~3. The ~~semi-annual Grant~~ Progress ~~Reports may require~~Report will include a breakdown of funding utilization by category as ~~mutually agreed upon~~required by ~~CalOptima Health and~~ the ~~Grantee~~Grant Agreement.

~~1. CalOptima Health may also utilize Grant Progress Reports to provide updates to CalOptima Health's executives and the CalOptima Health Board about its Grant funding activities.~~

~~2. Grantees shall also submit a final closeout report as stipulated in the Grant contract, summarizing the actions taken by the Grantee over the course of the entire Grant contract term.~~

~~a. The final closeout report will include a breakdown by category of the funds used, and a reconciliation to indicate all funds were used according to the intended purpose.~~

~~5.~~4. ~~As part of CalOptima Health's due diligence, CalOptima Health's designated representative(s) may also elect to~~ conduct site visits to a Grantee's business premises and/or site(s) of Grant-funded service delivery during the Grant ~~contract~~Agreement term for the following actions including, but not limited to:

a. Meet the Grantee's senior leadership, as well as the Grantee's staff or volunteers with primary responsibility for conducting the funded activities;

b. Engage in dialogue with the Grantee about progress toward project milestones and objectives, ~~notable~~ successes, implementation challenges, and early lessons learned;

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c. Learn of any anticipated requests for scope or budget changes, or no-cost ~~extensions~~extension; and

d. See program services/activities first-hand, if applicable and feasible.

~~6.~~5. Grant payments may be delayed or withheld if site visits and/or Grant Progress Reports reveal ~~Grantees are~~Grantee is not making sufficient progress towards ~~stated~~ goals or ~~are~~is not meeting other Grant ~~contract~~Agreement requirements. CalOptima Health may request that the Grantee realign performance objectives if deemed appropriate.

H. ~~If sufficient progress is not being made toward~~Post Award: Grant ~~contract goals and metrics,~~ Agreement Changes:

1. All Grant Agreement changes must be finalized prior to the expiration of the Grant Agreement.

2. Requests for changes must be received in writing.

3. CalOptima Health will determine whether a requested change is considered a limited change or a material change.

a. Limited Change

i. A limited change to a Grant Agreement does not affect the scope of work ~~with Grantees to understand why metrics were~~ or increase the Grant funding amount requested and is within the grant program parameters approved by the Board of Directors.

ii. A limited change may include but not ~~achieved~~be limited to:

a) A no-cost extension within the same fiscal year;

b) Expenditure shifts between line items in the originally approved budget but within the approved amount; and ~~work with~~

c) Minor resource shifts or changes from the original targeted project plan.

iii. If a requested change is determined to be limited in nature, the change can be approved by the Sponsoring Department.

b. Material Change

i. A material change to a Grant Agreement is a significant change that may include but not be limited to:

a) Significant changes to the targeted activities or outcome(s) funded by the grant award;

b) Any impact to the program schedule or duration causing delay to program implementation that impacts Board-approved funding, i.e. the grant period will extend into a new fiscal year; and

c) A significant reduction in the activities indicated in the Grant Agreement.

ii. If a change is determined to be material in nature, the change must be approved by the Sponsoring Department and the Board of Directors through the COBAR process.

4. If the request is approved, CalOptima Health staff will generate a Grant Agreement amendment document. The document will be sent electronically to the Grantee's point of contact. The document must be signed by the Official Signatory. All signatures on the Grant Agreement amendment must be obtained prior to expiration of the Grant Agreement. Notice of the fully executed Grant Agreement amendment will be sent electronically.

5. If the request is denied, CalOptima Health staff will provide documentation of the denial to the Grantee ~~to realign metrics~~.

I. Post Award: Grant Close-out Procedure

1. At the end of the Grant term, each Grantee will submit a Final Report as outlined in the Grant Agreement, summarizing the activities completed by the Grantee over the course of the entire Grant term, and analyzing its performance against the Grant objectives. The Final Report will include a breakdown by category of the funds used and a reconciliation to indicate all funds were used according to their intended purposes.

2. CalOptima Health will conduct a Grant close-out review that will:

a. Validate that the scope of work and performance objectives of the Grant Agreement were completed;

b. Verify final spending reports and reconcile with Finance;

c. Validate that all required Progress Reports were submitted;

d. Review Final Report for completeness;

e. Retain records for documents, reports, financial documentation, and any other related program artifacts in CalOptima Health SharePoint site; and

~~a.~~f. Conduct a lessons learned review, if ~~deemed appropriate.~~applicable.

3. CalOptima Health shall recoup any unspent grant funds after completion of the project as agreed to in the Grant Agreement.

J. Post Award: Grant Audit

~~7.~~1. CalOptima Health may conduct audits of the ~~Grantee~~Grantee's use of Grant funds and/or of the related CalOptima Health operational areas and financial data during the course of the Grant and/or at the conclusion of the Grant.

a. The audits will be conducted to confirm reported expenditures, performance measures, compliance with key Grant requirements, and other relevant factors as applicable to the specific Grant.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health ~~Strategic Plan~~ Policy AA.1204: Gifts, Honoraria, and Travel Payments
B. CalOptima Health Policy GA.5002: Purchasing
C. CalOptima Health Policy GA.5003: Budget and Operations Forecasting

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/04/2023	AA.1400	Grant Management	Administrative
Revised		AA.1400	Grant Management	Administrative

IX. GLOSSARY

Term	Definition
~~Grantee~~Confidential Information	~~A recipient of a grant.~~Any information designated as confidential or which, by its nature, a reasonable person would treat as confidential, given the character of the information and the circumstances of disclosure. It includes all non-public and proprietary information that has been disclosed to or obtained by the recipient from a third party or any other source. CalOptima's Confidential Information also includes all user information, member information, patient information, and clinical data that comes into CalOptima's possession, custody or control.
Covered Person	CalOptima Health employee, officer, Board of Directors (Board) Member, and agent of CalOptima Health.
Evaluation Committee	A Committee of qualified staff and subject matter experts appointed by CalOptima Health to review and assess Grant Applications and program proposals.
Final Report	A document providing information about the Grant project or program's final progress in achieving the goals and objectives of the Grant provided by the Grantee to CalOptima Health. The schedule of submission is set in the Grant Agreement.
~~Grants~~Grant	A financial award given by CalOptima Health to an eligible recipient to achieve a particular purpose or project. Grants are generally not expected to be repaid by the recipient when appropriately used for an approved ~~grant~~Grant project.
Grantee	A recipient of a Grant.
Grant Agreement	A funding agreement between CalOptima Health and the Grantee that sets the terms and conditions of a Grant.
Grant Application	A grant application submitted to CalOptima Health to formally request funding for a specific project.
Grant Award	The dollar amount awarded to the Grantee by CalOptima Health through the Grant Management Policy and Procedure.
Grants Management	CalOptima Health department responsible for overall Grant administration oversight.
Member	A beneficiary enrolled in a CalOptima Health program.
Notice of Funding Opportunity	CalOptima Health's formally issued announcement of the availability of a Board-approved and authorized Grant opportunity through one of its Community Investment programs.
Official Signatory	The designated representative of the applicant or grant recipient organization with authority to act on the organization's behalf in matters related to the award and its administration.
Progress Report	A document providing information about a project or program's progress in achieving the goals and objectives of a Grant.
~~Proposal~~Sponsoring Department	~~An application submitted to CalOptima Health used to formally request funding for a specific project.~~CalOptima Health department responsible for the design and development of Grant program requirements, review of Progress Reports, and review of the Final Report to ensure Grant program objectives and outcomes are achieved.
Strategic Plan	CalOptima Health's strategic priorities, objectives, and action plans.

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Policy:	AA.1400
Title:	**Grant Management**
Department:	Strategic Development
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	05/04/2023
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines the criteria for awarding Grant funds and the expectations of Grantees for discretionary Grant funding disbursed by CalOptima Health.

II. POLICY

A. Ethics

1. General Conduct

   a. Each Covered Person is subject to the Conflict of Interest Laws of the State of California (State) and the CalOptima Health Code of Conduct. Any Covered Person who violates these standards will be subject to the relevant penalties, sanctions, and other disciplinary actions.

2. Gratuities, Kickbacks, and Contingency Fees

   a. Except as allowed under CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments, no Covered Person may solicit or accept any personal gift or anything of value from any person or entity to which a Grant is under consideration for award, has been awarded, or may be awarded, or because of any action taken or to be taken in the performance of the Covered Person's duties. Any Covered Person failing to adhere to the above will be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, up to and including dismissal.

   b. CalOptima Health employees must adhere to all provisions of CalOptima Health Policies AA.1204: Gift, Honoraria, and Travel Payments, and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health.

3. Confidential Information

   a. No Covered Person may use Confidential Information, or information regarding a Grant that has not been made public or become subject to the California Public Records Act, for their actual or anticipated personal gain, or the actual or anticipated personal gain of any other person related to such Covered Person by blood, marriage, or by common commercial or financial interest. A Covered Person failing to adhere to this requirement will be subject

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to any disciplinary proceeding deemed appropriate by CalOptima Health, up to and including dismissal.

b. No Covered Person may divulge Confidential Information to any Grantee, vendor, consultant, or contractor outside the scope of any agreement that may exist with the Grantee, vendor, consultant, or contractor.

c. While a Notice of Funding Opportunity (NOFO) is active, to prevent unfair and inequitable treatment of applicants, no Covered Person may discuss the strengths and weaknesses of an applicant with any other applicants.

4. Personal Conflict of Interest

a. No Covered Person may participate in the selection, award, or administration of an agreement with a Grantee, or in any decision that may have a foreseeable impact on a Grantee if a conflict of interest, real or apparent, exists. Such a conflict arises when a Covered Person, or a Covered Person's spouse, children, or domestic or business partner, has an existing relationship with the applicant, is employed by or has received an offer of employment from the applicant, or is in a position to influence a decision that may result in personal or financial gain to the Covered Person or the Covered Person's spouse, children, or domestic or business partner, as a result of the Grantee's selection or award.

5. Organizational Conflict of Interest

a. Organizational conflicts of interest are circumstances that arise out of a party's business or financial interests, familial relationships, contractual relationships, organizational structure, or existing or past activities, including any prior interactions or work with CalOptima Health, that result or can result in influence on requirements, such as unreleased budgets, scopes of work, selection criteria, or unequal access to information, or the appearance or reality of impropriety or unfair advantage to the party.

b. No person or entity may submit a Grant application if the person or entity has:

i. Directly assisted in drafting or in preparing the specifications, requirements, or cost estimates for that Grant; or

ii. Had access and exposure to information pertinent to that Grant that was unavailable to other potential applicants and would provide a competitive advantage to its possessor.

B. Approach to Grant Management

1. When resources permit, CalOptima Health may designate authorized funds specifically for Board-approved Grant(s) to eligible external organizations.

2. CalOptima Health will ensure the distribution of Grant funds is reflective of CalOptima Health's mission, consistent with CalOptima Health's Strategic Plan, any Board-approved fund allocation plan, and/or any funding source legal parameters and funding restrictions.

3. Each Grant Application will receive a thorough, unbiased evaluation including, but not limited to, an assessment of an organization's experience, capacity, fiscal soundness, benefit to CalOptima Health Members, and feasibility.

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C. Approvals

1. Funding and funding reallocation for all Grant Awards will be approved by the Board through separate Board actions.

D. Grant Award Funds

1. Grant Award fund disbursements may only be approved by an authorized person pursuant to CalOptima Health's Policy GA.5002: Purchasing.

2. Any person in a position of delegated authority may designate a person of the same level or higher, in writing, to act in their stead when that person is unavailable.

3. Grant fund disbursement approval limits will be consistent with CalOptima Health's Policy GA.5002: Purchasing:

Employee Position	Approval Limit
Manager	$ 1,000
Director	$ 10,000
Executive Director or Officer	$ 100,000
CEO or Chief Operating Officer (COO)	$ Over 100,000

III. PROCEDURE

A. Pre-Award: Grant Authorization Requirements

1. Grants Management will coordinate program development and provide guidance on the grant-making process to initiative owners and/or Sponsoring Department as appropriate.

2. The Sponsoring Department will develop the requirements and criteria for the specific Grant.

3. The Sponsoring Department will develop a NOFO that outlines specific information about the Grant program. Refer to Section III.B. for NOFO requirements.

4. The Sponsoring Department will complete a CalOptima Health Board Action Agenda Referral (COBAR) for Board authorization of the Grant program.

B. Notice of Funding Opportunity (NOFO) Requirements

1. CalOptima Health will issue a NOFO for all Grant programs.

2. At a minimum, each NOFO will contain the following elements:

a. The title of the Grant program;

b. Goals and objectives of the Grant program;

c. The Grant availability period;

d. Key Dates, particularly due dates for questions and submission of applications;

e. Total Grant program amount;

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f. The minimum and maximum amount of each Grant, if applicable;

g. Specific eligibility requirements;

h. Evaluation criteria;

i. Instructions on submitting applications; and

j. CalOptima Health contact information and communication protocols.

3. CalOptima Health will post the NOFO on its website.

C. Pre-Award: Application Process

1. Upon Board approval of the Grant, CalOptima Health will develop an electronic Grant Application.

2. The electronic Grant Application will be published in the Grants Management system.

3. CalOptima Health may hold a webinar and will publish a frequently asked questions document about the funding opportunity during the application period.

4. Grant Applications will not be accepted after the application period closes.

D. Pre-Award: Grant Application Evaluation and Selection

1. CalOptima Health will select an Evaluation Committee for each NOFO consisting of CalOptima Health employees and, if needed, outside subject matter experts (SMEs).

2. Prior to receiving applications, Grants Management will identify the applicants to each member of the Evaluation Committee. Any person who has a conflict of interest, must inform Grants Management in writing and recuse themselves from further participation in the evaluation process. All persons given access to Grant Applications must document a confidentiality and conflict of interest statement.

3. Grant Applications will first be reviewed for eligibility. Applications that are ineligible will be rejected.

4. The Evaluation Committee will evaluate each Grant Application against the evaluation criteria established in the NOFO.

5. The Evaluation Committee will proceed as follows:

a. Review each Grant Application and score each application based on the Evaluation Criteria published in the NOFO;

b. Meet one or more times to discuss their evaluation results during the evaluation period; and

c. Recommend applicants for Grant Awards based on their scores and funding availability for Board approval.

d. An organizational financial review will be conducted for all or a subset of grant applicants to assess financial solvency.

6. Grant Award recommendations will be submitted for review and approval to the CalOptima Health Board.

7. Upon Board approval of one or more Grants, Grant Management will:

   a. Send written notification of their application status to all Grant applicants.

   b. Offer feedback to non-selected applicants if requested.

E. Grant Award: Establishing Measurable Objectives and Agreement Execution

1. CalOptima Health will ensure that all Grants have established one or more performance objectives that are measurable and documented in the Grant Agreement. These performance objectives will be the basis for Grant monitoring and reporting.

2. CalOptima Health will provide a formal Grant Award letter to the selected Grantee, including applicable templates for Progress Reports, a scope of work, and a Grant payment schedule.

3. Once the necessary documents, including certificate of insurance are obtained, a Grant Agreement will be executed between CalOptima Health and the Grantee.

   a. The Grant Agreement will be sent electronically to the Grantee's point of contact. The document must be signed by an individual who has the authority to legally bind the Grant(s) (Official Signatory).

   b. The Grantee will be given a sufficient number of days to review the Grant Agreement. CalOptima Health will work with the Grantee to finalize the Grant Agreement.

F. Post-Award: Payment of Grant Fund Disbursements

1. Upon receipt of the fully executed Grant Agreement, CalOptima Health will process payments according to the established payment schedule.

2. CalOptima Health will review Progress Reports, invoices, receipts, and other documentation to determine whether adequate progress has been achieved and that Grant fund expenditures are appropriate before releasing subsequent Grant fund disbursements.

3. Upon completion of the Grant program and closeout review, CalOptima Health will obtain any funds that are found to not have been utilized in accordance with the Grant Agreement.

G. Post-Award: Grant Performance Monitoring and Reporting Requirements

1. CalOptima Health will review Progress Reports and request meetings as needed to monitor compliance and progress towards achieving the objectives in the Grant Agreement.

2. The Grantee will submit Progress Reports based on schedule and frequency indicated in the Grant Agreement to CalOptima Health, detailing Grantee activities, along with any required supporting materials through the submission method agreed upon by Grantee and CalOptima Health Sponsoring Department.

3. The Progress Report will include a breakdown of funding utilization by category as required by the Grant Agreement.

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4. CalOptima Health may conduct site visits to a Grantee's business premises and/or site(s) of Grant- funded service delivery during the Grant Agreement term for the following actions including, but not limited to:

    a. Meet the Grantee's senior leadership, as well as the Grantee's staff or volunteers with primary responsibility for conducting the funded activities;

    b. Engage in dialogue with the Grantee about progress toward project milestones and objectives, successes, implementation challenges, and early lessons learned;

    c. Learn of any anticipated requests for scope or budget changes, or no-cost extension; and

    d. See program services/activities first-hand, if applicable and feasible.

5. Grant payments may be delayed or withheld if site visits and/or Grant Progress Reports reveal Grantee is not making sufficient progress towards goals or is not meeting other Grant Agreement requirements. CalOptima Health may request that the Grantee realign performance objectives if deemed appropriate.

H. Post Award: Grant Agreement Changes:

1. All Grant Agreement changes must be finalized prior to the expiration of the Grant Agreement.

2. Requests for changes must be received in writing.

3. CalOptima Health will determine whether a requested change is considered a limited change or a material change.

    a. Limited Change

        i. A limited change to a Grant Agreement does not affect the scope of work or increase the Grant funding amount requested and is within the grant program parameters approved by the Board of Directors.

        ii. A limited change may include but not be limited to:

            a) A no-cost extension within the same fiscal year;

            b) Expenditure shifts between line items in the originally approved budget but within the approved amount; and

            c) Minor resource shifts or changes from the original targeted project plan.

        iii. If a requested change is determined to be limited in nature, the change can be approved by the Sponsoring Department.

    b. Material Change

        i. A material change to a Grant Agreement is a significant change that may include but not be limited to:

a) Significant changes to the targeted activities or outcome(s) funded by the grant award;

b) Any impact to the program schedule or duration causing delay to program implementation that impacts Board-approved funding, i.e. the grant period will extend into a new fiscal year; and

c) A significant reduction in the activities indicated in the Grant Agreement.

ii. If a change is determined to be material in nature, the change must be approved by the Sponsoring Department and the Board of Directors through the COBAR process.

4. If the request is approved, CalOptima Health staff will generate a Grant Agreement amendment document. The document will be sent electronically to the Grantee's point of contact. The document must be signed by the Official Signatory. All signatures on the Grant Agreement amendment must be obtained prior to expiration of the Grant Agreement. Notice of the fully executed Grant Agreement amendment will be sent electronically.

5. If the request is denied, CalOptima Health staff will provide documentation of the denial to the Grantee.

I. Post Award: Grant Close-out Procedure

1. At the end of the Grant term, each Grantee will submit a Final Report as outlined in the Grant Agreement, summarizing the activities completed by the Grantee over the course of the entire Grant term, and analyzing its performance against the Grant objectives. The Final Report will include a breakdown by category of the funds used and a reconciliation to indicate all funds were used according to their intended purposes.

2. CalOptima Health will conduct a Grant close-out review that will:

a. Validate that the scope of work and performance objectives of the Grant Agreement were completed;

b. Verify final spending reports and reconcile with Finance;

c. Validate that all required Progress Reports were submitted;

d. Review Final Report for completeness;

e. Retain records for documents, reports, financial documentation, and any other related program artifacts in CalOptima Health SharePoint site; and

f. Conduct a lessons learned review, if applicable.

3. CalOptima Health shall recoup any unspent grant funds after completion of the project as agreed to in the Grant Agreement.

J. Post Award: Grant Audit

1. CalOptima Health may conduct audits of the Grantee's use of Grant funds and/or of the related CalOptima Health operational areas and financial data during the course of the Grant and/or at the conclusion of the Grant.

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a. The audits will be conducted to confirm reported expenditures, performance measures, compliance with key Grant requirements, and other relevant factors as applicable to the specific Grant.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
B. CalOptima Health Policy GA.5002: Purchasing
C. CalOptima Health Policy GA.5003: Budget and Operations Forecasting

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/04/2023	AA.1400	Grant Management	Administrative
Revised		AA.1400	Grant Management	Administrative

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IX. GLOSSARY

Term	Definition
Confidential Information	Any information designated as confidential or which, by its nature, a reasonable person would treat as confidential, given the character of the information and the circumstances of disclosure. It includes all non-public and proprietary information that has been disclosed to or obtained by the recipient from a third party or any other source. CalOptima's Confidential Information also includes all user information, member information, patient information, and clinical data that comes into CalOptima's possession, custody or control.
Covered Person	CalOptima Health employee, officer, Board of Directors (Board) Member, and agent of CalOptima Health.
Evaluation Committee	A Committee of qualified staff and subject matter experts appointed by CalOptima Health to review and assess Grant Applications and program proposals.
Final Report	A document providing information about the Grant project or program's final progress in achieving the goals and objectives of the Grant provided by the Grantee to CalOptima Health. The schedule of submission is set in the Grant Agreement.
Grant	A financial award given by CalOptima Health to an eligible recipient to achieve a particular purpose or project. Grants are generally not expected to be repaid by the recipient when appropriately used for an approved Grant project.
Grantee	A recipient of a Grant.
Grant Agreement	A funding agreement between CalOptima Health and the Grantee that sets the terms and conditions of a Grant.
Grant Application	A grant application submitted to CalOptima Health to formally request funding for a specific project.
Grant Award	The dollar amount awarded to the Grantee by CalOptima Health through the Grant Management Policy and Procedure.
Grants Management	CalOptima Health department responsible for overall Grant administration oversight.
Member	A beneficiary enrolled in a CalOptima Health program.
Notice of Funding Opportunity	CalOptima Health's formally issued announcement of the availability of a Board-approved and authorized Grant opportunity through one of its Community Investment programs.
Official Signatory	The designated representative of the applicant or grant recipient organization with authority to act on the organization's behalf in matters related to the award and its administration.
Progress Report	A document providing information about a project or program's progress in achieving the goals and objectives of a Grant.
Sponsoring Department	CalOptima Health department responsible for the design and development of Grant program requirements, review of Progress Reports, and review of the Final Report to ensure Grant program objectives and outcomes are achieved.
Strategic Plan	CalOptima Health's strategic priorities, objectives, and action plans.

Continued to the February 6, 2025 Board Meeting

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
16. Adopt a New CalOptima Health Fiscal Year 2025-2027 Strategic Plan

Contact
Donna Laverdiere, Executive Director of Strategic Development, (714) 986-6981

Recommended Action
1. Adopt the new CalOptima Health Fiscal Year 2025-2027 Strategic Plan.

Background
In December of 2021, CalOptima Health staff developed five strategic priorities and tactical priorities, and sought feedback from advisory committees, health networks, hospitals, and clinics among others. The strategic priority areas and tactical priorities were developed for 2022-2025 in alignment with the updated mission and vision the CalOptima Health Board of Directors (Board) formally adopted on March 17, 2022. The staff made consistent progress in operationalizing these strategic priorities, which demonstrated significant operational efficiencies and performance improvements within the organization. These efforts have resulted in improved member and provider experience, as well as increased community engagement, recognizing CalOptima Health's purpose and role in meeting the needs of Orange County residents and providers. CalOptima Health staff reported on accomplishments against the prior set of priorities in 2023.

To continue working toward a clear strategic roadmap for the upcoming years, CalOptima Health has developed a new Fiscal Year (FY) 2025-2027 Strategic Plan utilizing input from senior leadership and community partners, as well as best practices from other Medi-Cal managed care plans. A draft of the plan was presented to various stakeholder forums, leadership, and staff throughout the summer of 2024, as listed below:

- Member and Provider Advisory Committee – April 11, 2024
- Health Network Forum – May 16, 2024
- Whole Child Model Family Advisory Committee – June 18, 2024
- Monthly Community Health Centers Forum – July 12, 2024
- CalOptima Health Monthly All Staff Meeting – July 17, 2024
- Community Network Virtual Learn – September 25, 2024

Discussion
A discussion draft of the new FY 2025-2027 Strategic Plan was presented to the Board for review on November 7, 2024. CalOptima Health staff has revised the FY 2025-2027 Strategic Plan based on feedback received during and after the November Board meeting. Based on feedback received from the Board, the following revisions have been made to the FY 2025-2027 Strategic Plan.

- Revised the Vision Statement to be more succinct and address comments.

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- Revised the Values Statement.
- Revised the health equity-related goal 1.4 to include a focus on access to preventive services for vulnerable populations.
- Added a new goal 3.4 focused on grants management reporting and accountability.

The FY 2025-2027 Strategic Plan reflects broad stakeholder input and provides a clear strategic roadmap for CalOptima Health activities and investments through FY 2027.

The new FY 2025-2027 Strategic Plan consists of the following five components:

- Mission Statement - A mission statement defines the organization's business, its objectives, and how it will reach these objectives.
- Vision Statement - A vision statement details where the organization aspires to go.
- Values - Values articulate what the organization believes in and how it aspires to operate.
- Strategic Priorities - Strategic priorities are organizational priorities that provide guidance to leadership and signal the direction of the organization to the community.
- Organizational Goals - Organizational goals are a targeted set of goals for a three-year period that help prioritize activities and investments.

Mission Statement

CalOptima Health proposes in FY 2025-2027 to maintain the organization's current mission statement: *To serve member health with excellence and dignity, respecting the value and needs of each person.*

Vision Statement

CalOptima Health staff propose to revise the organization's vision statement to focus less on tactical strategies and more on the aspirations for the organization in terms of how CalOptima Health best serves its members. The proposed revised vision statement reads as follows: *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.*

Values

CalOptima Health proposes to memorialize our existing organizational values statement. The values statement reads as follows: *CalOptima Health C-A-R-E-S. We believe that to best serve the people of Orange County, we will lead with **C**ollaboration, **A**ccountability, **R**espect, **E**xcellence and **S**tewardship.*

Strategic Priorities

CalOptima Health staff propose four Strategic Priorities for the FY 2025-2027 Strategic Plan.

Strategic Priority	Definition
Equity and Population Health	CalOptima Health will infuse the pursuit of health equity throughout our work and will continue to innovate and develop tools and interventions that advance the physical, behavioral and social health of our members.
Quality and Value	CalOptima Health is committed to providing the highest quality of physical, behavioral and social health care to our members

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Strategic Priority	Definition
	and to ensuring sound stewardship of public dollars by achieving greater value.
Community Partnerships and Investment	CalOptima Health will continue to demonstrate our partnership with Orange County members, providers, county agencies and community organizations through Medi-Cal Transformation programs and robust community investments and partnerships to advance health equity.
Operational Excellence	CalOptima Health's continued investment in our performance is vital to ensuring the highest level of care and service to our members across their lifespan.

Organizational Goals

Within each Strategic Priority, CalOptima Health staff have developed three-year Organizational Goals. Each goal has a single accountable goal owner.

Equity and Population Health
1.1 Utilize technology and innovation to strengthen equity and population health management programs.
1.2 Implement a consistent model of care for population health/care management, including delegated networks.
1.3 Annually assess members' health and social needs and utilize data to develop targeted interventions.
1.4 Increase access to preventive services for vulnerable populations in pursuit of health equity.

Quality and Value
2.1 Achieve NCQA rating of 4-stars for Medi-Cal. Achieve CMS rating of 3.5-stars for Medicare.
2.2 Improve access to care by strengthening the delivery system through provider support and workforce initiatives.
2.3 Increase provider engagement through improved provider tools, data exchange, and collaboration.
2.4 Expand the delivery of behavioral health services, invest in the workforce, and drive quality improvement through innovation.

Community Partnerships and Investment
3.1 Expand social support services through Medi-Cal Transformation and other social health initiatives.
3.2 Expand community involvement in co-creation of solutions that best serve members.
3.3 Prioritize community investments that advance health equity, drive prevention, and improve access to care.
3.4 Ensure that all community investment programs include clear accountability metrics and regular performance monitoring requirements.

Operational Excellence
4.1 Improve the turnaround time for treatment authorization for direct and delegated networks.

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Operational Excellence
4.2 Improve the turnaround time for claims payment for direct and delegated networks.
4.3 Launch and grow programs that take care of our members and their families across their lifespan.
4.4 Optimize the Medicare line of business to improve the member retention rate and support growth.
4.5 Implement the comprehensive Digital Transformation strategic roadmap to improve member experience and efficiency.
4.6 Optimize member engagement functions to improve member retention, satisfaction, and outcomes.
4.7 Achieve the Board approved Administrative Loss Ratio (ALR) target.

Performance Metrics
CalOptima Health staff will report quarterly on a three-year performance metric for each Organizational Goal. Each performance metric will be tracked over the three-year period of the Strategic Plan. Baseline performance will be provided to track progress. Mitigation strategies will also be presented where performance is not on track. Draft three-year performance metrics are provided in Attachment 3.

Fiscal Impact
The recommended action has no immediate fiscal impact.

Rationale for Recommendation
The new FY 2025-2027 Strategic Plan provides a clear roadmap to support CalOptima Health in focusing its activities and investments on strategic priorities. Approval of the FY 2025-2027 Strategic Plan will facilitate execution against the identified Strategic Priorities and Organizational Goals.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Previous Board Action, June 2, 2022, Adopt Strategic and Tactical Priorities for 2022-2025.
2. FY 2025-2027 CalOptima Health Strategic Plan Summary Presentation.
3. FY 2025-2027 Strategic Plan Performance Metrics Summary.

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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CalOptima Board Action Agenda Referral

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
18. Adopt Strategic and Tactical Priorities for 2022-2025

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Action(s)
1. Adopt Strategic and Tactical Priorities for 2022-2025

Background and Discussion
CalOptima was created by the Orange County Board of Supervisors in 1993 as a County Organized Health System (COHS) to meet the needs or Orange County residents and providers in the Medicaid system.

In July of 1994, the CalOptima Board of Directors (Board) adopted the Mission, Goals, and Objective Statement for O.P.T.I.M.A as developed by the Provider Advisory Committee and the Consumer/Beneficiary Advisory Committee.

At that time, the Board wanted to ensure that the statement regarding the inclusion of the County-responsible indigent population in O.P.T.I.M.A was linked to the availability of adequate funding for services provided to this population.

The following mission was adopted and defined in Policy #AA. 1201:

- Mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

CalOptima also adopted the following vision statement:

- To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

In 2013, during a strategic planning session conducted by the Board updating the mission was considered. Ultimately, it was agreed up on that the original mission statement did not require any changes.

Today, CalOptima is the single largest health insurer in Orange County, providing coverage for one in four residents through four programs:

- Medi-Cal
- OneCare
- OneCare Connect

- PACE

On March 17, 2022, the Board formally adopted new mission and vision statements.

- Mission-To serve member health with excellence and dignity, respecting the value and needs of each person.
- Vision-By 2027, remove barriers to healthcare access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Beginning in December of 2021, staff developed five strategic priorities and tactical priorities. Over the last six months, CalOptima has sought feedback from advisory committees, health networks, hospitals, and clinics among others. The five strategic priority areas are as follows:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountability and Results Tracking
- Future Growth

The strategic priority areas and tactical priorities will support planning and development for CalOptima through 2025. Staff will return to the Board with a Strategic Plan using these priorities for approval.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Development of the proposed Strategic Priority Areas is consistent with the direction provided by the Board of Directors to support planning and development of CalOptima programs and initiatives.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Strategic Priorities One Pager
2. Resolution of New Mission and Vision Statement for CalOptima

/s/ Michael Hunn — *05/27/2022*
Authorized Signature — **Date**

Mission	*To serve member health with excellence and dignity, respecting the value and needs of each person.*				
Vision	*By 2027, remove barriers to healthcare access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.*				
Core Strategy	**The 'inter-agency' co-creation of services and programs, together with our delegated networks, providers, and community partners, to support the mission and vision.**				
Strategic Priorities 2022-2025	**Organizational and Leadership Development**	**Overcoming Health Disparities**	**Finance and Resource Allocation**	**Accountabilities & Results Tracking**	**Future Growth**
Tactical Priorities 2022-2025	• Cultural Alignment throughout CalOptima • Talent Development & Succession Planning • Effective & Efficient Organizational Structures • Aligned Operating Systems & Structures • Staff Leadership Development Institutes (Training) & Executive Coaching • Organizational Excellence Annual Priorities • On-going updated Policies & Procedures • Governance & Regulatory Compliance Trainings • Board Priorities	• CalOptima's 'Voice & Influence' • Local, Federal & State Advocacy • Collaboration with the County, HCA, BeWell, the Networks and Community Based Organizations • Support for Community Clinics & Safety Net Providers • Medical Affairs Value Based Care Delivery • CalAIM initiatives • Focus on Equity & Communities Impacted by Health Inequities • Co-Created Needs Assessment within Equity Communities & Neighborhoods • ITS Architecture that supports the Core Strategy • DHCS Comprehensive Quality Strategy	**Operating Budget Priorities** • Balanced Operating Budget • New Programs & Services Budgeting (CalAIM, DHCS Quality Strategy) • Fiscal Strategic Plan Priorities (KPI/KFI) • Quarterly Budget Reconciliation **Capital Budget Priorities** • Capital Planning & Asset Management, including Real-Estate Management and Acquisition(s) • New ITS Architecture **New Policy and Program Development based on Funding** • Reserve/Spending Policies & Priorities • Aligned Incentives for Network Quality & Compliance • Contracting & Vendor/Provider Management	• Updated By-Laws • Executive Priorities & Outcomes • COBAR Clarity • Inter-Agency Team Priorities • Public/Private Implementation Work Group • Resource Allocation for Inter-Agency Initiatives • Partner CalAIM Opportunities for Outcomes Metrics • Research Analytics for Efficacy Reporting (Metrics of Success) • Regular Board Training Sessions	• Member Access to Quality Care • Participate in Covered California • Site Utilization (PACE etc.) • Services/Programs Aligned with Future Reimbursements from DHCS and CMS • Demographic & Analytics by Micro-Community • ITS Data Sharing to benefit the member • Implement Programs & Services (CalAIM) & Plan for Site Locations • Industry Trends Analysis (Trade Associations, Lobbyists etc.) • Enhanced ITS security posture

DRAFT STRATEGIC AND TACTICAL PRIORITIES May_2022

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RESOLUTION NO. 22-0317-01

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

RESOLUTION FOR MISSION AND VISION STATEMENT

WHEREAS, the governing body of the Orange County Health Authority, dba CalOptima, ("CalOptima") adopted Mission, Goals, and Objective Statement O.P.T.I.M.A in July of 1994;

WHEREAS, this mission statement adopted in 1994 stated, the mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner;

WHEREAS, the adoption of the mission statement was reflected in Policy #AA. 1201;

WHEREAS, the governing body of CalOptima has adopted a new mission and vision statement on March 17, 2022 and will be reflected in Policy #AA. 1201;

WHEREAS, the governing body adopted CalOptima's new mission and vision statement as follows;

- Mission: To serve member health with excellence and dignity, respecting the value and needs of each person.
- Vision: By 2027, remove barriers to healthcare access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

NOW, THEREFORE, BE IT RESOLVED that the governing body of CalOptima adopts a new mission and vision statement.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 17th day of March 2022.

AYES: Becerra, Chaffee, Contratto, Corwin, Do, Mayorga, Schoeffel, Shivers

NOES: None

ABSENT: Tran

ABSTAIN: None

/s/ _____
Title: Chair, Board of Directors
Printed Name and Title: Andrew Do, Chair, CalOptima Board of Directors

Attest:
/s/ Sharon Dwiers
Sharon Dwiers, Clerk of the Board

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Continued to the February 6, 2025 Board Meeting

CalOptima Health

FY 2025-2027 Strategic Plan

Board of Directors Meeting
December 5, 2024

Donna Laverdiere, Executive Director, Strategic Development

Our Mission

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

Our Vision

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

Contents

- Components of the FY 2025-2027 Strategic Plan
- Mission Statement and Vision Statement
- CalOptima Health Values
- Four Strategic Priority Areas
- Three-Year Organizational Goals

Strategic Plan Components

Mission

A **mission statement** defines the organization's business, its objectives, and how it will reach these objectives.

Vision

A **vision statement** details where the organization aspires to go.

Values

Values articulate what the organization believes in and how it aspires to operate.

Strategic Priorities

Strategic Priorities are organizational priorities that provide guidance to leadership and signal the direction of the organization to the community.

Organizational Goals

Organizational Goals are a targeted set of goals for a three-year period that help prioritize activities and investments.

Mission and Vision Statements

- **Mission**
  - Maintain the current Mission Statement – *To serve member health with excellence and dignity, respecting the value and needs of each person.*
- **Vision**
  - Replace the current Vision Statement with a more aspirational statement:
    - *Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.*

CalOptima Health Values

- CalOptima Health currently utilizes a values statement internally. We are proposing to adopt this values statement as part of our Strategic Plan.
  - CalOptima Health **C-A-R-E-S** – We believe that to best serve the people of Orange County, we will lead with **C**ollaboration, **A**ccountability, **R**espect**, E**xcellence and **S**tewardship.

Four Strategic Priority Areas

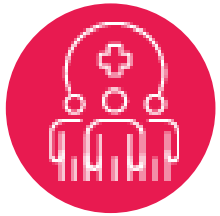
- For FY 2025-2027, CalOptima Health will focus on four strategic priority areas to achieve our mission, vision and values.

Equity & Population Health

Description	Organizational Goals
CalOptima Health will infuse the **pursuit of health equity** throughout our work and will continue to **innovate and develop tools** and interventions that advance the physical, behavioral and social health of our members.	1.1 Utilize technology and innovation to strengthen health equity and population health management programs.
	1.2 Implement a consistent model of care for population health and care management, including delegated networks.
	1.3 Annually assess members' health and social needs and utilize data to inform targeted interventions.
	1.4 Increase access to preventive services for vulnerable populations in pursuit of health equity.

Quality & Value

Description	Organizational Goals
CalOptima Health is committed to providing the **highest quality of physical, behavioral and social health care** to our members and to ensuring **sound stewardship of public dollars** by achieving greater value.	2.1 Achieve NCQA rating of 4 stars for Medi-Cal. Achieve CMS rating of 3.5 stars for Medicare.
	2.2 Improve access to care by strengthening the delivery system through provider support and workforce initiatives.
	2.3 Increase provider engagement through improved provider tools, data exchange and collaboration.
	2.4 Expand the delivery of behavioral health services, invest in the workforce and drive quality improvement through innovation.



Community Partnerships & Investments

Description	Organizational Goals
CalOptima Health will continue to demonstrate our **partnership with Orange County members, providers, county agencies and community organizations** through Medi-Cal Transformation programs and robust community investments and partnerships to **advance health equity.**	3.1 Expand social health services through Medi-Cal Transformation programs and additional social needs.
	3.2 Launch a comprehensive framework for community collaboration to co-create equitable solutions.
	3.3 Prioritize community investments that advance health equity, drive prevention and improve access to care.
	3.4 Ensure that all community investment programs include clear accountability metrics and regular performance monitoring requirements.

Operational Excellence

Description	Organizational Goals
CalOptima Health's continued investment in our **performance** is vital to ensuring the **highest level of care and service** to our members across their lifespan.	4.1 Improve the turnaround time for treatment authorizations for direct and delegated networks.
	4.2 Improve the turnaround time for claims payment for direct and delegated networks.
	4.3 Launch and grow new programs that take care of our members and their families across their lifespan.
	4.4 Optimize the Medicare line of business to improve member retention rate and support growth.
	4.5 Implement the comprehensive Digital Transformation strategic roadmap.
	4.6 Optimize member engagement functions to improve member retention, satisfaction and outcomes.
	4.7 Achieve the Board-approved ALR target.

CalOptima Health

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Working Draft – December 2024

FY 2025-2027 Strategic Plan – 3-year Performance Metrics Summary – WORKING DRAFT

Organizational Goal	Goal Owner	3-Year Performance Metric	Baseline	3-year Performance Target
1. Equity & Population Health				
1.1 Utilize technology and innovation to strengthen equity and population health management programs.	Marie Jeannis	% compliance with HbA1c Control for Patients with Diabetes (HBD) - Adequate Control <8.0% measure	58.7%	60.3%
1.2 Implement a consistent model of care for population health/care management, including delegated networks.	Kelly Giardina	% of members successfully enrolled in Complex Case Management	New Measure	0.05% (approx. 400 members)
1.3 Annually assess members' health and social needs and utilize data to develop targeted interventions.	Marie Jeannis	% of new members assessed for social needs and referred for appropriate interventions within 60 days	New Measure	30%
1.4 Increase access to preventive services for vulnerable populations in pursuit of health equity.	Dr. Michaell Rose	% compliance with Prenatal and Postpartum Care (PPC) measures	Prenatal Care: 88.1% (< 66th percentile) Postpartum Care: 80% (< 66th percentile)	Prenatal and Postpartum Care (PPC) measures ≥ 90th percentile
2. Quality & Value				
2.1 Achieve NCQA rating of 4-stars for Medi-Cal. Achieve CMS rating of 3.5-stars for Medicare.	Linda Lee	Medi-Cal Star Rating Medicare Star Rating	Medi-Cal: 3.5 Medicare: 2.5	Medi-Cal: 4 Medicare: 3.5
2.2 Improve access to care by strengthening the delivery system through provider support and workforce initiatives.	Michael Gomez	% of our providers meeting Time and Distance standards – Plan and Subdelegate level (DHCS)	CCN: 100% Health Network: 97.3%	CCN: 100% Health Network: 100%

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Organizational Goal	Goal Owner	3-Year Performance Metric	Baseline	3-year Performance Target
2.3 Increase provider engagement through improved provider tools, data exchange, and collaboration.	Michael Gomez	Overall provider satisfaction score	New Measure	70%
2.4 Expand the delivery of BH services, invest in the workforce, and drive quality improvement through innovation.	Carmen Katsarov	% Follow-Up After Emergency Department Visit for Mental Illness (FUM) within 30 days	15% (<33rd percentile)	60% (90th percentile)
3. Community Partnerships & Investments				
3.1 Expand social support services through Medi-Cal Transformation and other social health initiatives.	Dr. Kelly Bruno-Nelson	# of members served through Street Medicine	250	750
3.2 Expand community involvement in co-creation of solutions that best serve members.	Dr. Michaell Rose	# of individuals who attend or participate in community listening sessions, focus groups, or stakeholder engagement sessions	New Measure	20% increase in participation annually
3.3 Prioritize community investments that advance health equity, drive prevention, and improve access to care.	Donna Laverdiere	% of net income allocated to community investments in health equity, prevention, and access to care	6.5%	7.5% (DHCS-designated percentage)
3.4 Ensure that all community investment programs include clear accountability metrics and regular performance monitoring requirements.	Donna Laverdiere	% of grant agreements in compliance with reporting requirements	New Measure	100%
4. Operational Excellence				
4.1 Improve the turnaround time for treatment authorization for direct and delegated networks.	Kelly Giardina	Treatment authorization processing time for all providers	New Measure	10% reduction compared to previous year
4.2 Improve the turnaround time for claims payment for direct and delegated networks.	Ladan Khamseh	Claims auto-adjudication rate	Medi-Cal: 80% OneCare: 70%	Medi-Cal: 84% OneCare: 74%

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Organizational Goal	Goal Owner	3-Year Performance Metric	Baseline	3-year Performance Target
4.3 Launch and grow programs that take care of our members and their families across their lifespan.	Donna Laverdiere	Membership by Line of Business	OneCare: 17,282 PACE: 503 Covered CA: N/A	OneCare: 30,000 PACE: 700 Covered CA: 10,000 (pending)
4.4 Optimize the Medicare line of business to improve the member retention rate and support growth.	Javier Sanchez	Voluntary Disenrollment rate	8%	5%
4.5 Implement the comprehensive Digital Transformation strategic roadmap to improve member experience and efficiency.	Donna Laverdiere	% of Digital Transformation projects completed on time and within budget	100%	100%
4.6 Optimize member engagement functions to improve member retention, satisfaction, and outcomes.	Ladan Khamseh	CAHPS Rating of Health Plan	2	4
4.7 Achieve the Board approved ALR target.	Nancy Huang	Quarterly ALR measure	4.5%	Below 7%

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

17. Approve Actions Related to Covered California Consulting Support Contracts and Associated Funding

Contacts

Veronica Carpenter, Chief Administrative Officer, (657) 900-1161
Donna Laverdiere, Executive Director, Strategic Development, (714) 986-6981

Recommended Actions

Contingent upon and effective immediately following a second reading and majority vote of the Orange County Board of Supervisors to adopt an amendment to Section 4-11-2 of the Codified Ordinances of the County of Orange to remove the prohibition on CalOptima Health's participation in Covered California, enact the following:

1. Approve the scopes of work related to the following Covered California consulting support contracts:
    a. Strategic Advice and Qualified Health Plan Application Support;
    b. Actuarial Support for Financial Projections and Rate Development; and
    c. Operational Implementation Support and Project Management;
2. Approve the release of a request for proposals related to the Operational Implementation Support and Project Management contract;
3. Make exceptions to CalOptima Health Policy GA.5002: Purchasing and authorize the Chief Executive Officer, or designees, to execute the following contracts and/or contract amendments with the designated vendors without competitive procurement:
    a. Strategic Advice and Qualified Health Plan Application Support with Health Management Associates, Inc. through a contract amendment; and
    b. Actuarial Support for Financial Projections and Rate Development with Milliman, Inc. through a new direct contract;
4. Approve the creation of a restricted Covered California Start-up Reserve Fund in the amount of $4.75 million from existing reserves to fund Covered California start-up costs through December 31, 2026.

Background

On August 1, 2024, the CalOptima Health Board of Directors (Board) authorized the Chief Executive Officer (CEO) to convene a stakeholder steering committee comprised of key external partners and providers to discuss considerations for potential participation in Covered California. In addition, the Board authorized staff to conduct stakeholder listening sessions and other presentations to solicit feedback from broader partners and the community at large. Subsequently, CalOptima Health leadership and staff convened the Covered California Stakeholder Steering Committee (Committee) and engaged with the Committee, providers, community members and other key stakeholders through several forums and channels. Specifically, the Committee has now convened on four separate occasions and has discussed timeline, resource needs, and licensure milestones.

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Based upon the positive and informative feedback received through external engagement efforts, on October 3, 2024, the Board directed the CEO to request the Orange County Board of Supervisors (BOS) to amend CalOptima Health's governing ordinance to remove the prohibition on participation in Covered California. The BOS is scheduled to consider a first and second reading of an amended ordinance on December 3 and 17, respectively.

At the same meeting on October 3, 2024, the Board adopted formal guiding principles to inform CalOptima Health's participation in Covered California, and also authorized the continued regular convening of the Committee to inform ongoing operational and regulatory considerations. The seven guiding principles are as follows:

1. Through Covered California participation, provide continuous, high-quality care to our members across changes in life circumstances.
2. Ensure sufficient provider reimbursement in alignment with the current Covered California market in Orange County.
3. Consistently engage external stakeholders on an ongoing basis to inform the design, development and implementation of the program in a transparent way.
4. Be strong stewards of public funds by identifying opportunities for efficiency and careful investment in needed capabilities.
5. Ensure ongoing reinvestment in the Orange County community as a key tenet of Covered California participation.
6. Start small, and target individuals and families churning on and off Medi-Cal coverage.
7. Ensure network adequacy to support access and availability to care for our members.

Discussion

Pending a successful vote to adopt an amended ordinance by the BOS, CalOptima Health will require initial consulting contracts to facilitate and support implementation of a Covered California program ahead of a planned market entry date of January 1, 2027. The Covered California program necessitates the creation and operation of individual market health plans, which requires CalOptima Health to start a new line of business within its existing infrastructure.

The three requested contracts in this Board action represent the professional services needed to assist with developing the new Covered California line of business. The objectives included in the requested scopes of work (SOWs) include preliminary deliverables that must be completed for the Board to assess the business viability and advisability of program launch. The costs outlined below represent the estimated costs for professional services through the start-up period, up to and including the first open enrollment period and planned go-live on January 1, 2027, up to a total of $4.75 million. In Fiscal Year (FY) 2024-25, CalOptima Health expects to spend an estimated $1.1 million to conduct the upfront assessments and analyses needed to inform development of the program. Costs estimated for FY 2025-26 and FY 2026-27 represent support for project management, implementation, and ongoing support for operationalizing the new program.

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Contracted Support Estimated Costs	3-Year Investment
Strategic Advice and Qualified Health Plan (QHP) Application Support	**$250,000**
Actuarial Support for Financial Projections and Rate Development	**$1,500,000**
Operational Implementation Support and Project Management	**$3,000,000**
TOTAL	**$4,750,000**

More information about the procurement approaches and SOWs associated with the three requested contracts can be found in each subsection below. The three SOWs are also attached in full and provide additional detail on the services that would be utilized. No requested actions related to these procurements or contracts will be taken until the BOS has successfully voted to adopt an amended ordinance.

Strategic Advice and QHP Application Support
The strategic advice and QHP application support consultant will provide specific subject matter expertise to CalOptima Health to help guide leadership and the Board throughout the development of the new product line and the submission of the QHP application to Covered California. The consultant selected for this contract needs to bring experience gained from assisting other local Medi-Cal plans with developing Covered California products and with successfully completing the QHP application and contract negotiation process. Deliverables over the start-up period are as follows:

FY 2025	FY 2026	FY 2027
• Network strategy • QHP Application requirements inventory • QHP contract and Knox-Keene Act requirements side-by-side analysis	• Knox-Keene Act licensure filing expertise • QHP Application support	• QHP Application and contract support

For this contract, staff requests an exception to CalOptima Health Policy GA.5002: Purchasing, Section II.C.3, which requires a formal procurement for purchases of non-medical professional services and other contracts where the expected cost is estimated to be more than $250,000. CalOptima Health staff request approval to utilize a contract amendment to the existing contract with Health Management Associates, Inc. (HMA) to expand the scope and extend the timeframe of the contract without competitive procurement. Given that CalOptima Health is already contracted with HMA for strategic advice on growth opportunities, including Covered California, this amended contract would augment HMA's activities to focus on Covered California market entry strategy through the full start-up period ending December 31, 2026. The HMA team that would be included also supported Inland Empire Health Plan (IEHP) and L.A. Care Health Plan (L.A. Care) in implementing their Covered California products.

Actuarial Support for Financial Projections and Rate Development
Additional actuarial support with specific expertise in the individual market is required to support CalOptima Health with upfront and ongoing work necessary to develop and operate a QHP product.

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The actuarial support services contractor will develop medical, pharmacy, and dental preliminary capitation rates, a 5-year financial performance pro forma, and all actuarial work necessary up to and including the final rate filing for market entry in Covered California. This support is necessary to develop provider reimbursement rates and financial projections to support the development of the CalOptima Health provider network and to inform stakeholders and the Board on the financial investments and performance expected through this new line of business. Deliverables over the start-up period are as follows:

FY 2025	FY 2026	FY 2027
• Initial rates for medical, dental, and pharmacy benefits • Actuarial portions of the individual product filings • 5-year financial projections	• Updated rates • Rate filings • Updated financial projections	• Updated rates • Rate filings • Updated financial projections

For this contract, staff requests an exception to CalOptima Health Policy GA.5002: Purchasing, Section II.C.3, which requires a formal procurement for purchases of non-medical professional services and other contracts where the expected cost is estimated to be more than $250,000. CalOptima Health requests approval to directly contract with Milliman, Inc. without competitive procurement for Covered California actuarial support services consistent with CalOptima Health's current approach to actuarial support services provided by Milliman, Inc. for other lines of business.

Operational Implementation Support and Project Management
Development of a new line of business will have impacts across all CalOptima Health operational areas and will require a consultant to manage the overall readiness and operational implementation across the organization throughout the start-up period. The consultant will conduct a detailed gap analysis to identify capabilities that can be leveraged for Covered California, as well as gaps in people, processes, and technology that will require investment. This activity will assist CalOptima Health with developing a clear Information Technology (IT) roadmap and staffing plan for the new line of business. This consultant will also provide ongoing project management support for the implementation projects identified through the detailed gap analysis and roadmap development. Deliverables over the start-up period are as follows:

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FY 2025	FY 2026	FY 2027
• Detailed gap assessment and plan to close gaps • Vendor solution identification assistance • Detailed implementation roadmap and project plan • Operational workflow development • Lessons learned from IEHP and L.A. Care related to Covered California product implementation	• Project management support across all core operations and IT system implementation • Support for initial Open Enrollment Period operations and troubleshooting	• Implementation support for product launch and stabilization

For this contract, CalOptima Health will use a competitive procurement process to identify a contractor consistent with CalOptima Health Policy GA.5002: Purchasing. Following the release of the request for proposals authorized by this Board action, staff will return to a future Board meeting in spring of 2025 to request approval of a contract with the recommended vendor resulting from the competitive procurement process.

Funding Requests
Pending a successful vote to adopt an amended ordinance by the BOS, this Board action will create a restricted Covered California Start-up Reserve Fund in the amount of $4.75 million. This amount will fund the full terms of the above three professional contracts through December 31, 2026, to secure the necessary expertise and ensure continuity to support a successful product launch. Of note, staff is bringing a separate Board action to this meeting requesting additional funding for legal services related to Knox-Keene licensure activities, also subject to the BOS approval of the amended ordinance.

Staff will return to the Board in June 2025 with a funding request for remaining start-up costs that will encompass additional contracted support, systems implementation contracts, and staffing costs necessary for product launch, estimated to be no earlier than January 1, 2027. In June 2025, staff will also seek approval from the Board to continue to pursue launching a Covered California line of business and the submission of the Knox-Keene Act licensure filing.

Fiscal Impact
An allocation of up to $4.75 million from existing reserves will fund this action through December 31, 2026.

Rationale for Recommendation
The recommended actions will allow CalOptima Health to procure the necessary professional services to develop a new Covered California line of business.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Proposed SOW for Strategic Advice and QHP Application Support
2. Proposed SOW for Actuarial Support for Financial Projections and Rate Development
3. Proposed SOW for Operational Implementation Support and Project Management
4. Entities Covered by This Recommended Action

/s/ Michael Hunn *11/27/2024*
Authorized Signature **Date**

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DRAFT Scope of Work Professional Services and Consultant Support for CalOptima Health's Qualified Health Plan (QHP) Application Submission

1.1 Project Objectives

CalOptima is interested in becoming part of Covered California to ensure that more Orange County residents have access to affordable health insurance coverage and health care when they are not eligible for Medi-Cal. CalOptima is seeking a consultant to provide comprehensive and strategic guidance on business strategy and regulatory requirements for the Qualified Health Plan (QHP) Application submission process, Knox-Keene Act licensed plan requirements, and the QHP contract needed for market participation in Covered California.

1.2 Provider Network Design Strategic Support

Provide strategic advice related to the development of the contracted provider network for the Covered CA line of business.

1.2.1 Covered CA product network design considerations.

1.2.2 Quality requirements and contracting considerations.

1.2.3 Market intelligence.

1.2.4 Division of Financial Responsibility.

1.2.5 QHP Application network submission.

1.3 Comprehensive Strategic Support and Guidance Related to QHP Application, Contract, and Knox-Keene Act Licensed Plan Requirements

Provide strategic advice related to meeting the regulatory requirements for participation in Covered California throughout the application process and rate negotiations.

1.3.1 Knox-Keene Act licensed plan and QHP contract requirements.

1.3.2 QHP Application requirements.

1.3.3 Quality components of Knox-Keene Act licensure and the QHP contract, including quality transformation requirements, measurement requirements, reporting, and penalties.

1.3.4 Benefit plan designs, provider network, special enrollment documents, member materials (EOC, Schedule of Benefits, Member ID), provider or administrative service contract(s) unique to Exchange etc. (i.e., billing/premium collection, pediatric dental).

1.3.5 CMS Health Insurance Oversight System (HIOS) Filings: Benefit Plan Designs, Drug Formulary, and Plan Management filings.

1.3.6 Regulatory rate filings done through the System for Electronic Rate and Form Filing (SERFF) of the National Association of Insurance Commissioners (NAIC).

1.4 QHP Application Submission Review

Review licensure and QHP Application filing documents for completeness and compliance as needed. Provide advice and suggest changes to help ensure successful QHP certification.

1.4.1 Review QHP certification application materials and provide consultation, as requested.

1.4.2 Review licensure application materials and provide consultation, as requested.

1.4.3 Review benefit plan designs, provider network, special enrollment documents, member materials (EOC, Schedule of Benefits, Member ID), and other key regulatory filings, and provide consultation as requested.

1.4.4 By April 30, 2026, assist with completing QHP certification filings to secure Covered California approval for benefit plans commencing January 1, 2027, including rate negotiations.

1.5 Strategic Advice Related to Operational Requirements and Timeline

Provide strategic advice on operational requirements that must be met by CalOptima Health to complete the QHP application to enroll and serve Covered California enrollees for benefits starting January 1, 2027.

1.5.1 Infrastructure, plan management and staffing (CalHEERS testing/interface, member effectuation and reconciliation, call center, key plan functions, compliance program).

1.5.2 Financial (rate development, billing/collection, accumulator, risk-adjustment).

1.5.3 Member-related (enrollment, effectuation, communication, policies/procedures, customer service standards, access to care, quality/value).

1.5.4 Provider-related (network adequacy/stability, essential community providers, access for rural and traditionally underserved populations, special rules governing American Indians and Alaskan Natives).

1.5.5 Certified agents (Appointment, Agent of Record delegation, compensation, training, and communication).

1.5.6 Marketing and advertising (Co-branding, filings, and reporting)

1.5.7 Customer service standards (Capacity and turn-around requirements, training and communication, self-monitoring, and reporting).

1.5.8 Training and communication (Members, staff, certified agents, provider network, contractors, and vendors).

1.5.9 Quality improvement and disparities reduction programs.

1.5.10 Open enrollment and special enrollment periods.

1.5.11 Transparency and reporting (claims payment policies and practices, periodic financial disclosures, enrollment, disenrollment, claims denials, appeals, rating practices, cost-sharing, payments with respect to any out-of-network coverage, and Enrollee rights).

1.6 Responsibilities are specified below:

1.6.1 Complete all deliverables (refer to section E for detailed list).

1.6.2 Be available and prepared for meetings (both virtually and in person at CalOptima Health's offices).

1.6.3 Provide a consultant representative to be available via telephone or email to respond to CalOptima Health's questions or concerns within one business day.

1.6.4 Coordinate activities and tasks needed to meet regulatory requirements and provide oversight.

1.6.5 Provide a monthly status summary of progress toward deliverables.

1.6.6 Provide documentation and requested deliverables pursuant to the scope of work on time and on budget.

1.7 CalOptima Responsibilities

CalOptima Health will provide necessary resources and management involvement to support the delivery of service to perform within an agreed upon timeframe.

1.7.1 Be available for interviews/questions and meetings.

1.7.2 Make staff available for project collaboration.

1.7.3 Supply artifacts required to meet the scope of work objectives.

1.7.4 Provide feedback on all resources.

1.8 Deliverables

No.	Deliverable	Purpose of Deliverable	Format, if applicable	Time Frame
1	Network Strategy	Strategic advice on the design of the CalOptima Health Covered CA provider network	PowerPoint presentations, Network documents	Complete by February 28, 2025
2	Comprehensive Summary of QHP Application Requirements and Timeline	Inventory all regulatory filing and QHP application requirements that must be met by the plan to obtain approval as a QHP carrier and issuer.	Word or Excel file	Complete by April 30, 2025
3	Detailed Side-by-Side Analysis	Provide a detailed side-by-side analysis of Knox Keene licensed plan requirements and QHP contract requirements, identifying what standards must to met as well as reporting requirements.	Word, Excel, or PowerPoint file	Complete by April 30, 2025
4	Knox Keene Licensure Filing Subject Matter Expertise	Review of specific licensure filing documents as needed.	Word, Excel	Complete by December 31, 2025
5	QHP Application Support	Strategic advice and document review to support the QHP Application and negotiation process	PowerPoint presentations, meeting attendance	Complete by September 30, 2026

SECTION 1 - SCOPE OF WORK

1.1 Project Objectives

CalOptima Health plans to join the Covered California market for the 2027 plan year. CalOptima intends to ensure that more Orange County residents have access to affordable health insurance coverage and quality care when they are not eligible for Medi-Cal.

1.2 Scope of Work

CalOptima is seeking development of medical, pharmacy, and dental preliminary capitation rates, a 5-year financial performance pro forma, and all actuarial work necessary up to and including the final rate filing for market entry in Covered California for plan year 2027. The selected consultant will provide the following services.

1.2.1 Delegated group and specialty subcontractor preliminary capitation rate development

A. Create a range of reasonable professional and institutional capitation rates based on market intelligence of Orange County's prevailing rates.

B. Create a range of reasonable specialty plan subcontractor rates (if not given) for pharmacy and dental benefits in the Orange County market.

C. With input from CalOptima Health staff, propose a draft commercial division of financial responsibility (DOFR) for medical benefits.

D. Using the draft commercial DOFR, build up preliminary cap pricing by DOFR line item including utilization and unit cost assumptions.

1.2.2 5-year financial performance pro forma

Based on reasonable actuarially sound assumptions, create a working model with projections that CalOptima Health may use to set expectations with stakeholders, be used as a financial road map for staff to inform the budget process, and fulfill necessary regulatory fillings including but not limited to support the "material modification" in submission of the QHP.

1.2.3 Areas of Focus:

A. Benefit plan designs,

B. Relative risk adjustment that influences final net premium revenues (transfer payment projections) and factors that influence utilization assumptions,

C. Likely mix of membership including metal tier distribution,

D. Non-claim expense assumptions including taxes and fees

1.3 CY 2027 Covered California rate development and final rate filing

Ensure timely, accurate, filing for all actuarial work in support of plan year 2027 rate documents.

1.3.1 Assemble a project plan from data collection to submission, including required deliverables from CalOptima Health staff to meet plan year 2027 benefit, actuarial value, and rate filing requirements.

1.3.2 Identify and collect from CalOptima Health staff needed information required to generate a first pass of premium rate projections. Information will include expected population counts, demographics, historical experience under Medi-Cal, expected provider network design (e.g., subcontractor, delegated, risk-bearing subcontracted entity, direct), expected provider network contractual rate arrangements, etc.

1.3.3 Creation of a first pass of rate projections, including development of preliminary network and demographic assumptions based on market intelligence with sufficient detail for review with CalOptima Health staff.

1.3.4 Based on feedback following the first pass, create a second pass of rate projections with needed network or medical management changes required to meet targeted premium rates. Implement additional iterations as needed.

1.3.5 Assemble, submit, and certify the final plan year 2027 rate filing documents for submission to Covered California and DMHC.

1.3.6 Document and report out all assumptions and methodologies used to develop the rate filing.

1.3.7 Engage in Covered California rate discussions and negotiations with regulators as necessary.

1.4 Annual support of financial operations post go-live

Provide support for reviews and audits of materials supplied by contractor to Covered California and regulators as needed.

1.5 Contractor Responsibilities:

1.5.1 Provide all deliverables.

1.5.2 Be available and prepared for Covered California filing meetings (both virtually and in person at CalOptima Health's offices).

1.5.3 Provide a representative that be available via telephone or email to respond to CalOptima Health's questions or concerns within one business day.

1.5.4 Coordinate activities and tasks needed to meet regulatory requirements and provide oversight.

1.5.5 Provide a monthly status summary of progress toward deliverables.

1.5.6 Provide documentation and requested deliverables pursuant to the scope of work on time and on budget

1.6 CalOptima Responsibilities

CalOptima Health will provide necessary resources and management involvement to support Contractor's delivery of services. Staff will be available for interviews, meetings, and project collaboration.

1.7 Deliverables

No.	Deliverable	Purpose of Deliverable	Format, if applicable	Time Frame
1	Initial fully capitated rates for medical, dental, and pharmacy benefits by metal benefit tier and age/sex band.	For planning.	MS Excel	Complete by February 28, 2025
2	5-year financial projections including all financial statements and calculations of tangible net equity.	For planning and satisfaction of regulatory interest in the financial position of CalOptima Health.	MS Excel including as determined by Covered CA and regulators	Complete by March 30, 2025
3	Actuarial portions of the individual product filings to Covered California including resubmissions as needed.	Necessary for the approval of a CalOptima Health individual Covered California product offering on the exchange.	As determined by Covered CA and regulators	Complete by December 31, 2025

1.8 Minimum Qualifications

- 10 years in actuarial healthcare consulting business
- At least one assigned staff member qualified under applicable laws and regulations to make certified statements of actuarial opinion
- 5 years of experience assisting health plans with requirements related to the rate filing process to Covered California

1.9 Pricing

Provide pricing per deliverable, and include hourly rates for post go-live support.

1.10 Staff Requirements

1.10.1 Provide names and titles of staff that will be involved with the project.

1.10.2 Identify working hours and time zones of staff assigned to the project.

1.10.3 Provide evidence of past engagement for assigned staff in:

A. An initial Covered California product launch

B. Renewal premium rate filings with Covered California

Professional Services for Operational Readiness and Implementation Support of CalOptima Health's Participation in Covered California

SECTION 1 - SCOPE OF WORK

1.1 Project Objectives

CalOptima is interested in becoming part of Covered California to ensure that Orange County residents have access to affordable health insurance coverage and quality health care when they are not eligible for Medi-Cal.

CalOptima is seeking professional services that include end-to-end implementation consultation and project management support across all operations and marketplace line-of-business functions, i.e., benefits administration, customer service, grievances and appeals, medical management, quality, care management, premium collection and reconciliation, risk adjustment, IT, reporting requirements, and other services. Services include support through navigation of open enrollment and post-stabilization monitoring.

1.2 Operational Gap Assessment and Gap Closure Analysis

1.2.1 Identify infrastructure and functions that must be modified, enhanced, or added by CalOptima Health for benefit year starting on January 1, 2027.

1.2.2 Conduct a thorough assessment including interviewing all functional leads, reviewing current functions and infrastructure, and identifying opportunities presented by in-flight systems enhancements. Include recommendations for closing existing gaps in the areas of people, process and technology, as well as build vs. buy options.

1.2.3 Conduct a lessons learned review of implementation experiences at Inland Empire Health Plan (IEHP) and LA Care based on their experience implementing the Covered CA line of business. Provide a lessons learned analysis that outlines mitigation strategies for identified areas of risk.

1.3 Business Process Mapping for Core Functions and IT

Develop business process mapping for internal departments that improves core operational functions and IT applications, ensuring that they comply with regulatory requirements and implement best practices/industry standards across all marketplace plan functions.

1.4 Outside Vendor Assistance

Identify functions that may not be performed internally by CalOptima Health but are essential to secure Covered California participation, providing the following:

1.4.1 Assistance with identifying functions that could be outsourced (i.e., billing/collection, accumulator, risk adjustment, data reporting, self-service tools for members, etc.).

1.4.2 Guidance in developing business requirements and scopes of work for outsourced functions.

1.4.3 General project management support to implement outsourced functions to secure timely regulatory approval.

1.5 Comprehensive Implementation Support and Project Management

1.5.1 Provide comprehensive project management support to close operational gaps, launch new functions, implement changes to existing functions, and assistance to oversee IT system builds to launch the commercial products (on and off exchange). Partner closely with CalOptima Health business owners and project managers to provide this ongoing project management support.

1.5.2 Develop a detailed implementation roadmap and work plan in Microsoft Project or another project management tool. The roadmap will take into consideration gap closure, operational readiness, cost estimates, staffing estimates, project milestones, and status reporting.

1.5.3 Meet regularly with CalOptima to report on project status, risks, mitigation strategies, and other project management issues.

1.5.4 Provide the following:

A. A detailed project plan that highlights the work breakdown structure and schedule to meet all implementation requirements. This includes tasks, meeting schedules, activities, resources and duration to accomplish a successful implementation, as well as post-implementation monitoring.

B. Weekly status reports that document progress and communicate decisions as well as any risks or issues.

C. Facilitate project team meetings across functional areas in collaboration with CalOptima's business owners and project stakeholders toward implementation objectives and timeline.

1.6 Implementation Support for Product Launch and Stabilization

1.6.1 Ensure timely completion of carrier requirements for CalOptima's inaugural year of Covered California participation and continuous enhancement of product line operations.

1.6.2 Provide the following services:

A. Assist with the implementation activities including completion of Open Enrollment Period (OEP) milestones, timely posting of regulator-approved plan documents, member enrollment and effectuation processes, premium billing and collection functions, timely distribution of member materials, general member on-boarding cross-functional activities, and related Covered California communication/reporting requirements.

B. Provide consultation, as requested, to support customer service functions, including Call Center staff training and internal/external communication of OEP policies and procedures, and Covered California OEP requirements and plan-specific OEP product guidelines.

C. Assist in evaluating OEP complications, identifying effective resolution and deploying timely corrective action, as needed.

D. Provide general project management support, as requested, to ensure compliance with Covered California OEP reporting/contract requirements (e.g., enrollment/effectuation volume, customer service metrics, marketing/advertising spend amounts, etc.).

E. Provide general project management support, as required, to launch the commercial products (on and off exchange), and to stabilize the line of business following the completion of Open Enrollment Period (OEP) activities.

F. Provide consultation, as requested, in evaluating the deployment of the Special Enrollment Period (SEP) and the member retention/renewal implementation plans.

G. Assist in evaluating identified deficiencies related to product implementation, plan operation, and/or regulatory/contractual reporting, and assessing the deployment of efficient and timely solutions, as needed.

H. Compile a high-level post-implementation assessment to document "lessons learned" during the product launch and OEP, identifying any consideration/recommendation for ongoing product operations and market strategy.

I. Assist CalOptima Health with troubleshooting any issues, risks, or process challenges identified upon go-live.

1.7 Deliverables

No.	Deliverable	Purpose of Deliverable	Format, if applicable	Time Frame
1	Detailed Gap Assessment and Plan to Close Gaps	Comprehensive gap assessment and identification of strategies to close gaps	Word or Excel file	Complete by May 31, 2025
2	Vendor Procurement Strategic Advice	Identify qualified vendor options for functions that will be outsourced or where off-the-shelf products are needed. Assist with scope of work and business requirements for procurement.	Word or Excel File	Complete by June 30, 2025
3	Lessons Learned from Inland Empire Health Plan (IEHP) and LA Care Covered CA implementation experience	Documentation of lessons learned from IEHP and LA Care's implementation of Covered CA in key functional areas including premium collection and reconciliation, pricing, etc.	PowerPoint presentation	Complete by June 30, 2025
4	Business Processing Mapping	Operational workflow mapping for all core operations areas impacted by Covered CA line of business needs	Visio or other platform as appropriate	Complete by July 31, 2025
5	Detailed Implementation Roadmap and Project Plan	Comprehensive roadmap and work plan for Covered CA implementation	PowerPoint presentations, MS Project or other project management software	Complete by July 31, 2025
6	Project Management Support	Ongoing project implementation support across all impacted functional areas, including project management for IT system implementation	Meeting minutes, weekly status reports, risk escalation, project management	Weekly throughout the entire contract period
7	Implementation Support for the Inaugural Open Enrollment Period (OEP)	Ensure timely completion of QHP requirements for a successful Open Enrollment Period.	Completion of OEP activities	Complete by December 31, 2026
8	Implementation Support for Product Launch and Stabilization	Ensure timely completion of carrier requirement for the plan's inaugural year of Covered California participation and continuous enhancement of product line operations.	Word or Excel document, and project management tasks assigned	Complete by March 31, 2027

1.8 General Contractor Responsibilities:

1.8.1 Complete all deliverables (refer to section C for detailed list of deliverables).

1.8.2 Develop project plans highlighting the work-breakdown structure and schedule to meet the scope of work.

1.8.3 Be available and prepared for operational implementation meetings (both virtually and in person at CalOptima Health's offices).

1.8.4 Provide project managers and an accountable account representative to be available via telephone or email to respond to CalOptima Health's questions or concerns within one business day.

1.8.5 Coordinate and implement the project requirements and provide oversight.

1.8.6 Provide a weekly status summary of progress toward deliverables and all implementation activities.

1.8.7 Provide documentation and requested deliverables pursuant to the scope of work on time and on budget.

1.9 CalOptima Responsibilities

CalOptima will provide necessary resources and management involvement to support the delivery of services.

SECTION 2 - CONTRACTOR MINIMUM REQUIREMENTS

- 10 years in business
- 5 years of experience assisting health plans with operational readiness and implementation for successful market entry into heath insurance exchange programs, including Covered CA

SECTION 3 - PRICING

Provide pricing per deliverables and an hourly rate for consultants, using the attached pricing sheet

Professional Services for Operational Readiness and Implementation Support of CalOptima Health's Participation in Covered California

No.	Deliverable	Time Frame	Hourly Rate	No. of Hours	TOTAL COST
1	Detailed Gap Assessment and Plan to Close Gaps	Complete by May 31, 2025			
2	Vendor Procurement Strategic Advice	Complete by June 30, 2025			
3	Lessons Learned from Inland Empire Health Plan (IEHP) and LA Care Covered CA implementation experience	Complete by June 30, 2025			
4	Business Processing Mapping	Complete by July 31, 2025			
5	Detailed Implementation Roadmap and Project Plan	Complete by July 31, 2025			
6	Project Management Support	Weekly throughout the entire contract period			
7	Implementation Support for the Inaugural Open Enrollment Period (OEP)	Complete by December 31, 2026			
8	Implementation Support for Product Launch and Stabilization	Complete by March 31, 2027			
9	Detailed Gap Assessment and Plan to Close Gaps	Complete by May 31, 2025			
10	Vendor Procurement Strategic Advice	Complete by June 30, 2025			
		TOTAL			

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Health Management Associates, Inc.	2501 Woodlake Circle, Suite 100	Okemos	MI	48864
Milliman, Inc.	4370 La Jolla Village Drive, Suite 700	San Diego	CA	92122

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

18. Authorize Unbudgeted Expenditures and Appropriate Funds in the CalOptima Health Fiscal Year 2024-25 Operating Budget for Legal Services

Contact

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

Recommended Actions

Authorize unbudgeted operating expenditures and appropriate funds in an amount up to $2.5 million from existing reserves to fund legal services through June 30, 2025.

Background

On June 6, 2024, the CalOptima Health Board of Directors (Board) approved the CalOptima Health Fiscal Year 2024-25 Operating Budget (FY25 Budget). The budget included $3.35 million for professional legal services provided by CalOptima Health's general legal counsel firm Kennaday Leavitt PC (Kennaday Leavitt), professional legal services provided by other CalOptima Health contracted outside legal counsel, including Procopio, Cory, Hargreaves & Savitch (Procopio) and Woodruff-Sawyer & Co. (Woodruff), and other special counsel obtained through Kennaday Leavitt (*e.g.*, conflict counsel), and legal fees. This amount reflected a 5% increase from the prior fiscal year and was based on historical utilization and current anticipated legal services to support operations and management.

Discussion

Since the approval of the FY25 Budget, CalOptima Health has and will engage in unanticipated legal activities that will incur additional legal expenses. These activities include:

- Additional compliance and audit related activities conducted by Kennaday Leavitt and external counsel and specialty services retained through CalOptima Health and Kennaday Leavitt;
- Anticipated litigation services provided by Kennaday Leavitt, Procopio, Woodruff, and other CalOptima Health external counsel that may be retained through Kennaday Leavitt; and
- Regulatory licensure preparations provided by Kennaday Leavitt.

The above activities are critical for CalOptima Health to implement Board-approved strategic and operational initiatives. Staff estimates a budget not to exceed $2.5 million in operating expenses through June 30, 2025, to sufficiently cover the additional and necessary legal services.

The following is an estimate of the costs for the above additional legal services:

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Activity	**Estimated Cost (amount not to exceed)**
Additional compliance and audit related activities	$750,000
New and anticipated litigation	$1,000,000
Knox-Keene licensure activities (upon approval of ordinance change)	$750,000
TOTAL	$2,500,000

Staff will not request legal services for Knox-Keene licensure activities prior to amendment of CalOptima Health's County Ordinance by the County of Orange Board of Supervisors to allow CalOptima Health to explore participation in Covered California. Knox-Keene licensure activities will include preparation and review of extensive regulatory filings and engagement with the Department of Managed Health Care on each filing.

Fiscal Impact
The recommended action is unbudgeted. An appropriation of up to $2.5 million from existing reserves will fund the recommended action through June 30, 2025.

Rationale for Recommendation
Staff recommends approval of this action to cover legal services costs that were not planned or known at the time of the FY25 Budget approval.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
19. Authorize Actions Related to the Homeless Prevention and Stabilization Pilot Program

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

Recommended Actions
1. Authorize the Chief Executive Officer, or designee, to negotiate and execute a contract with the University of California, Irvine, to evaluate the effectiveness of the Homeless Prevention and Stabilization Program, effective no earlier than January 1, 2025;
2. Authorize up to $270,000 from existing reserves to fund the contract with the University of California, Irvine, through June 30, 2027; and
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background
In January 2024, the County of Orange Board of Supervisors (Board of Supervisors) approved the creation of the Homeless Prevention and Stabilization Pilot (HPSP) Program. The HPSP Program combines homelessness prevention and robust case management aimed at promoting housing stability. The HPSP program is a short-term (no longer than 12-months) financial intervention provided to households made up of individuals or families at risk of homelessness or experiencing a housing crisis. The goal is to achieve housing stability, to pay rental arrears, past due utility bills (electricity, gas, water, and trash), and forward rent and/or utility bills based on financial need. The robust case management focuses on developing financial stability and supportive services plans to identify community-based programs and resources that support the household in achieving housing stability. The expected program enrollment for households is 12-months, based upon need and evaluated on a quarterly basis. The HPSP Program is an initiative of Supervisor Vicente Sarmiento, Second District, that was unanimously supported by the Board of Supervisors and looks to invest in Homelessness Prevention, the first pillar of the Commission to End Homelessness's Homeless Service System Pillars Report, by targeting households who face imminent eviction and keeping them stably housed. The HPSP Program's goal is to promote stability in the lives of households facing eviction and assist them through direct payments, wrap around services, and case management to keep them housed with about one-tenth of the cost.

On February 1, 2024, the CalOptima Health Board of Directors (Board) authorized the planning and coordination of California Advancing and Innovating Medi-Cal (CalAIM) services for CalOptima Health members who enroll in the HPSP Program. The HPSP Program aligns with CalOptima Health's strategic priorities to address social determinants of health and enhance the quality of life for members. The program's goals aim to complement CalOptima Health's ongoing efforts to support members experiencing homelessness through initiatives such as street medicine, investments in permanent supportive housing, and CalAIM support services.

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In June 2024, the Board of Supervisors approved a Memorandum of Understanding (MOU) with the University of California, Irvine (UCI) to conduct an outcome evaluation of the HPSP Program to identify whether and how the HPSP Program improved the experience of Orange County households.

In August 2024, the County of Orange contracted with Orange County United Way-211(OCUW) to serve as the provider for the HPSP Program (see Attachment 1). Under the contract, OCUW coordinates the provision of all components of the HPSP Program including community outreach, application process, case management, financial disbursement, and coordination with additional supportive services.

Discussion

UCI's evaluation of the HPSP Program uses a combination of administrative data and data from surveys administered by UCI faculty. According to UCI, data is collected for both the HPSP Program participants (100 households in the treatment group) and a sample of similar individuals not enrolled in the program (200 households in the comparison group). The evaluation is divided into 2 cohorts based on enrollment year (Year 1 and Year 2). Participants and comparison group individuals receive an intake survey, a 6-month follow-up survey, and an 18-month follow-up survey. The evaluation will capture the following outcomes from program participants:

- Housing stability;
- Financial stability/employment;
- Health and well-being; and
- Utilization of program funds (treatment group only).

As part of the MOU between the County of Orange and UCI, the County of Orange approved the use of $100,000 from the Second District to fund UCI to launch the evaluation of the HPSP Program. The launch period from January 1, 2024, through December 31, 2024, covered the following:

- Design of comprehensive surveys;
- Integration of the surveys into software, enabling participants to complete the survey online via phone or computer;
- Translation of the baseline survey to ensure accessibility for diverse participants; and
- Collection of baseline data from up to 54 participants in the first cohort. (The collection of baseline surveys from the first cohort of participants continues.)

The second portion of the evaluation, scheduled to be completed between January 1, 2025, and June 30, 2027, is currently unfunded and would include the following (see Attachment 2):

- Continued data collection and survey administration for the two cohorts;
- Administering baseline, 6-month, and 18-month surveys for both cohorts; and
- A final report by June 30, 2027.

As described in Attachment 2, the evaluation timeline is as follows:

Timeline	Deliverable
January 1, 2025	Continue to collect baseline survey responses for Cohort 1 and populate secure database with responses
April - May 2025	Administer 6-month survey for Cohort 1

Timeline	Deliverable
October 2025	Administer baseline survey for Cohort 2
April - May 2026	Administer 6-month survey for Cohort 2 Administer 18-month survey for Cohort 1
April - May 2027	Administer 18-month survey for Cohort 2
June 30, 2027	Submit final report

UCI requests funding of $269,703, to complete the evaluation of the HPSP Program (see Attachment 3). CalOptima Health will release funds pursuant to contract provisions and receipt of required deliverables. The estimated total budget from UCI includes:

Budget Item	Estimated Amount
Staff (faculty staff and graduate student support)	$237,139
Other expenses (travel, translation)	$6,000
Indirect costs (facilities and administrative costs)	$26,564
TOTAL	**$269,703**

Upon Board approval, staff will develop, negotiate and execute a contract with UCI to complete the second portion of the evaluation. UCI is not requesting any member data; all data will be collected directly from the surveys, ensuring privacy and confidentiality. The contract will include deliverables and milestones consistent with this approval and the attached scope of work, and any other requirements consistent with CalOptima Health Medi-Cal program, regulatory, and contractual requirements.

Fiscal Impact

The recommended action to authorize up to $270,000 to support the evaluation of the HPSP Program will be funded from undesignated reserves.

Rationale for Recommendation

The evaluation of the HPSP Program will provide insights into strategies for reducing homelessness and improving health outcomes for members experiencing homelessness, including insights into the specific challenges CalOptima Health members face, particularly regarding housing instability. These insights will support CalOptima Health's ability to assess barriers to stable housing, improve care coordination, and deliver more effective solutions to support members in achieving better health outcomes.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Attachment 1: Contract between County of Orange and Orange County United Way
2. Attachment 2: HPSP Outcomes Scope of Work
3. Attachment 3: HPSP Budget Narrative

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Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
February 1, 2024	Approve Actions Related to Homelessness Prevention and Stabilization Pilot Program	n/a	none

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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CONTRACT MA-017-24011491

FOR

HOMELESSNESS PREVENTION AND STABILIZATION PILOT PROGRAM

BETWEEN

COUNTY OF ORANGE

AND

ORANGE COUNTY'S UNITED WAY DBA ORANGE COUNTY UNITED WAY

AUGUST 12, 2024 – AUGUST 11, 2026

This Contract ("Contract") entered into this 12th day of August, 2024 ("effective date"), is by and between the County of Orange, a political subdivision of the State of California ("County"), and Orange County's United Way dba Orange County United Way, a California nonprofit corporation, ("Contractor"). County and Contractor may sometimes be referred to herein individually as "Party" or collectively as "Parties." This Contract shall be administered by County Executive Office or an authorized designee ("Administrator").

W I T N E S S E T H:

WHEREAS, County wishes to contract with Contractor for Homeless Prevention and Stabilization Pilot Program described herein for the residents of Orange County; and

WHEREAS, Contractor is agreeable to the rendering of such services on the terms and conditions hereinafter set forth:

NOW, THEREFORE, in consideration of the mutual covenants, benefits, and promises contained herein, County and Contractor do hereby agree as follows:

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REFERENCED CONTRACT PROVISIONS

Term: August 12, 2024, through August 11, 2026

Maximum Obligation: $2,999,999.67

Basis for Reimbursement: Actual Costs

Payment Method: Arrears

Contractor's Tax ID Number: 33-0047994

Contractor's DUNS Number: 076064914

Contractor's Unique Entity Identifier Number: TWL3WEV59TH4

Notices to County and Contractor:

County:
County of Orange/CEO
County Procurement Office
400 West Civic Center, 5th floor
Santa Ana, CA 92701
CEOcarecoordination@ocgov.com

Contractor:
Orange County's United Way
18012 Mitchell South
Irvine, CA 92614
Attn: AnnR@UnitedWayOC.org

1. ACRONYMS

The following standard definitions are for reference purposes only and may or may not apply in their entirety throughout this Contract (additional Common Terms and Definitions are included in Paragraph "I" of Attachment A):

A. AB	Assembly Bill
B. AB 109	Assembly Bill 109, 2011 Public Safety Realignment
C. AIDS	Acquired Immune Deficiency Syndrome
D. APR	Annual Performance Report
E. ARRA	American Recovery and Reinvestment Act of 2009
F. BCSH	Business, Consumer Services and Housing Agency
G. BHS	Behavioral Health Services
H. Cal ICH	California Interagency Council on Homelessness
I. CalWORKs	California Work Opportunity and Responsibility for Kids
J. CAP	Corrective Action Plan
K. CCC	California Civil Code
L. CCR	California Code of Regulations
M. CDBG	Community Development Block Grant
N. CDSS	California Department of Social Services
O. CEO	County of Orange County Executive Office
P. CES	Coordinated Entry System
Q. CFDA	Catalog of Federal Domestic Assistance
R. CFR	Code of Federal Regulations
S. CoC	Continuum of Care
T. COI	Certificate of Insurance
U. CPA	Certified Public Accountant
V. CPP	Care Plus Program
W. CPRA	California Public Request Act
X. CSW	Clinical Social Worker
Y. DHCS	California Department of Health Care Services
Z. EEOC	Equal Employment Opportunity Commission

AA. ESG	Emergency Solutions Grant
AB. EOC	Equal Opportunity Clause
AC. ES	Emergency Shelter
AD. FTE	Full Time Equivalent
AE. GAAP	Generally Accepted Accounting Principles
AF. HCA	County of Orange Health Care Agency
AG. HCD	California Department of Housing and Community Development
AH. HCV	Housing Choice Voucher
AI. HHAP	Homeless, Housing, Assistance and Prevention
AJ. HIPAA	Health Insurance Portability and Accountability Act of 1996, Public Law 104-191
AK. HIV	Human Immunodeficiency Virus
AL. HMIS	Homeless Management Information System
AM. HOME	HOME Investment Partnership Program
AN. HUD	U.S. Department of Housing and Urban Development
AO. LCSW	Licensed Clinical Social Worker
AP. MH	Mental Health
AQ. MHP	Mental Health Plan
AR.MHSA	Mental Health Services Act
AS. OCCR	Orange County Community Resources
AT. OCR	Federal Office for Civil Rights
AU. OIG	Federal Office of Inspector General
AV. OMB	Federal Office of Management and Budget
AW. OPM	Federal Office of Personnel Management
AX. P&P	Policy and Procedure
AY. PATH	Projects for Assistance in Transition from Homelessness
AZ. PC	California Penal Code
BA. PHI	Protected Health Information
BB. PII	Personally Identifiable Information
BC. PSC	Professional Services Contract System
BD. PSH	Permanent Supportive Housing

BE. RRH	Rapid Rehousing
BF. SB	Senate Bill
BG. SIR	Self-Insured Retention
BH. SOCDIS	System of Care Data Integration System
BI. SOW	Scope of Work
BJ. SPA	Service Planning Area
BK. SUD	Substance Use Disorder
BL. TAY	Transitional Aged Youth
BM. UOS	Units of Service
BN. USC	United States Code
BO. VASH	Veterans Affairs Supportive Housing
BP. WIC	Women, Infants and Children
BQ. YAB	Youth Advisory Board

2. ALTERATION OF TERMS

A. This Contract, together with Attachment A and Exhibit A attached hereto and incorporated herein, fully expresses the complete understanding of County and Contractor with respect to the subject matter of this Contract.

B. Unless otherwise expressly stated in this Contract, no addition to, or alteration of the terms of this Contract or any Attachments/Exhibits, whether written or verbal, made by the Parties, their officers, employees or agents shall be valid unless made in the form of a written amendment to this Contract, which has been formally approved and executed by both Parties.

3. ASSIGNMENT OF DEBTS

Unless this Contract is followed without interruption by another Contract between the Parties hereto for the same services and substantially the same scope, at the termination of this Contract, Contractor shall assign to County any debts owing to Contractor by or on behalf of persons receiving services pursuant to this Contract. Contractor shall immediately notify by mail each of the respective Parties, specifying the date of assignment, the County of Orange as assignee, and the address to which payments are to

be sent. Payments received by Contractor from or on behalf of said persons, shall be immediately given to County.

4. CONFIDENTIALITY

A. Contractor shall maintain the confidentiality of all records, including billings and any audio and/or video recordings, in accordance with all applicable federal, state and county codes and regulations, as they now exist or may hereafter be amended or changed.

B. Prior to providing any services pursuant to this Contract, all members of the Board of Directors or its designee or authorized agent, employees, consultants, subcontractors, volunteers and interns of the Contractor shall agree, in writing, with Contractor to maintain the confidentiality of any and all information and records which may be obtained in the course of providing such services. This Contract shall specify that it is effective irrespective of all subsequent resignations or terminations of Contractor members of the Board of Directors or its designee or authorized agent, employees, consultants, subcontractors, volunteers and interns.

5. CONFLICT OF INTEREST

Contractor shall exercise reasonable care and diligence to prevent any actions or conditions that could result in a conflict with County interests. In addition to Contractor, this obligation shall apply to Contractor's employees, agents, and subcontractors associated with the provision of goods and services provided under this Contract. Contractor's efforts shall include, but not be limited to establishing rules and procedures preventing 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 County staff or elected officers in the performance of their duties.

6. COST REPORT

A. Contractor shall submit a Cost Report to County no later than forty-five (45) calendar days following termination of this Contract. Contractor shall prepare the Cost Report

in accordance with all applicable federal, state and County requirements, GAAP and the Special Provisions Paragraph of this Contract. Contractor shall allocate direct and indirect costs to and between programs, cost centers, services, and funding sources in accordance with such requirements and consistent with prudent business practice, which costs and allocations shall be supported by source documentation maintained by Contractor, and available at any time to Administrator upon reasonable notice.

1. If Contractor fails to submit an accurate and complete Cost Report within the time period specified above, Administrator shall have sole discretion to impose one or both of the following:
    a) Contractor may be assessed a late penalty of five-hundred dollars ($500) for each business day after the above specified due date that the accurate and complete Cost Report is not submitted. Imposition of the late penalty shall be at the sole discretion of the Administrator. The late penalty shall be assessed separately on each outstanding Cost Report due County by Contractor.
    b) Administrator may withhold or delay any or all payments due Contractor pursuant to any or all Contracts between County and Contractor until such time that the accurate and complete Cost Report is delivered to Administrator.
2. Contractor may request, in advance and in writing, an extension of the due date of the Cost Report setting forth good cause for justification of the request. Approval of such requests shall be at the sole discretion of Administrator and shall not be unreasonably denied.
3. In the event that Contractor does not submit an accurate and complete Cost Report within one hundred and eighty (180) calendar days following the termination of this Contract, and Contractor has not entered into a subsequent or new Contract for any other services with County, then all amounts paid to Contractor by County during the term of the Contract shall be immediately reimbursed to County.

B. The Cost Report shall be the final financial and statistical report submitted by Contractor to County, and shall serve as the basis for final settlement to Contractor.

Contractor shall document that costs are reasonable and allowable and directly or indirectly related to the services to be provided hereunder. The Cost Report shall be the final financial record for subsequent audits, if any.

C. Final settlement shall be based upon the actual and reimbursable costs for services hereunder, less applicable revenues and any late penalty, not to exceed County's Maximum Obligation as set forth in the Referenced Contract Provisions of this Contract. Contractor shall not claim expenditures to County which are not reimbursable pursuant to applicable federal, state and County laws, regulations and requirements. Any payment made by County to Contractor, which is subsequently determined to have been for an unreimbursable expenditure or service, shall be repaid by Contractor to County in cash, or other authorized form of payment, within thirty (30) calendar days of submission of the Cost Report or County may elect to reduce any amount owed Contractor by an amount not to exceed the reimbursement due County.

D. If the Cost Report indicates the actual and reimbursable costs of services provided pursuant to this Contract, less applicable revenues and late penalty, are lower than the aggregate of interim monthly payments to Contractor, Contractor shall remit the difference to County. Such reimbursement shall be made, in cash, or other authorized form of payment, with the submission of the Cost Report. If such reimbursement is not made by Contractor within thirty (30) calendar days after submission of the Cost Report, County may, in addition to any other remedies, reduce any amount owed Contractor by an amount not to exceed the reimbursement due County.

E. If the Cost Report indicates the actual and reimbursable costs of services provided pursuant to this Contract, less applicable revenues and late penalty, are higher than the aggregate of interim monthly payments to Contractor, County shall pay Contractor the difference, provided such payment does not exceed the Maximum Obligation of County.

F. All Cost Reports shall contain the following attestation, which may be typed directly on or attached to the Cost Report:

"I HEREBY CERTIFY that I have executed the accompanying Cost Report and

supporting documentation prepared by _____ for the cost report period beginning _____ and ending _____ and that, to the best of my knowledge and belief, costs reimbursed through this Contract are reasonable and allowable and directly or indirectly related to the services provided and that this Cost Report is a true, correct, and complete statement from the books and records of (provider name) in accordance with applicable instructions, except as noted. I also hereby certify that I have the authority to execute the accompanying Cost Report.

Signed _____

Name _____

Title _____

Date _____"

7. **DEBARMENT AND SUSPENSION CERTIFICATION**

A. Contractor certifies that it and its principals:

1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency.
2. Have not within a three-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property.
3. Are not presently indicted for or otherwise criminally or civilly charged by a federal, state, or local governmental entity with commission of any of the offenses enumerated in Subparagraph A.2. above.
4. Have not within a three-year period preceding this Contract had one or more public transactions (federal, state, or local) terminated for cause or default.
5. Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR Part 9,

Subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction unless authorized by the State of California.

6. Shall include without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion Lower Tier Covered Transaction," (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 2 CFR Part 376.

B. The terms and definitions of this paragraph have the meanings set out in the Definitions and Coverage sections of the rules implementing 51 F.R. 6370.

8. DELEGATION, ASSIGNMENT, AND SUBCONTRACTS

A. Contractor may not delegate the obligations hereunder, either in whole or in part, without prior written consent of County. Contractor shall provide written notification of Contractor's intent to delegate the obligations hereunder, either in whole or part, to Administrator not less than sixty (60) calendar days prior to the effective date of the delegation. Any attempted assignment or delegation in derogation of this paragraph shall be void.

B. Contractor agrees that if there is a change or transfer in ownership of Contractor's business prior to completion of this Contract, and County agrees to an assignment of the Contract, the new owners shall be required under the terms of sale or other instruments of transfer to assume Contractor's duties and obligations contained in this Contract and complete them to the satisfaction of County. Contractor may not assign the rights hereunder, either in whole or in part, without the prior written consent of County.

1. If Contractor is a nonprofit organization, any change from a nonprofit corporation to any other corporate structure of Contractor, including a change in more than fifty percent (50%) of the composition of the Board of Directors within a two (2) month period of time, shall be deemed an assignment for purposes of this paragraph, unless Contractor is transitioning from a community clinic/health center to a Federally Qualified Health Center and

has been so designated by the Federal Government. Any attempted assignment or delegation in derogation of this subparagraph shall be void.

2. If Contractor is a for-profit organization, any change in the business structure, including but not limited to, the sale or transfer of more than ten percent (10%) of the assets or stocks of Contractor, change to another corporate structure, including a change to a sole proprietorship, or a change in fifty percent (50%) or more of Board of Directors or any governing body of Contractor at one time shall be deemed an assignment pursuant to this paragraph. Any attempted assignment or delegation in derogation of this subparagraph shall be void.
3. If Contractor is a governmental organization, any change to another structure, including a change in more than fifty percent (50%) of the composition of its governing body (i.e. Board of Supervisors, City Council, School Board) within a two (2) month period of time, shall be deemed an assignment for purposes of this paragraph. Any attempted assignment or delegation in derogation of this subparagraph shall be void.
4. Whether Contractor is a nonprofit, for-profit, or a governmental organization, Contractor shall provide written notification of Contractor's intent to assign the obligations hereunder, either in whole or part, to Administrator not less than sixty (60) calendar days prior to the effective date of the assignment.
5. Whether Contractor is a nonprofit, for-profit, or a governmental organization, Contractor shall provide written notification within thirty (30) calendar days to Administrator when there is change of less than fifty percent (50%) of Board of Directors or any governing body of Contractor at one time.
6. County reserves the right to immediately terminate the Contract in the event County determines, in its sole discretion, that the assignee is not qualified or is otherwise unacceptable to County for the provision of services under the Contract.

C. Contractor's obligations undertaken pursuant to this Contract may be carried out by means of subcontracts, provided such subcontractors are approved in advance by Administrator, meet the requirements of this Contract as they relate to the service or

activity under subcontract, include any provisions that Administrator may require, and are authorized in writing by Administrator prior to the beginning of service delivery.

1. After approval of the subcontractor, Administrator may revoke the approval of the subcontractor upon five (5) calendar days' written notice to Contractor if the subcontractor subsequently fails to meet the requirements of this Contract or any provisions that Administrator has required. Administrator may disallow subcontractor expenses reported by Contractor.
2. No subcontract shall terminate or alter the responsibilities of Contractor to County pursuant to this Contract.
3. Administrator may disallow, from payments otherwise due Contractor, amounts claimed for subcontracts not approved in accordance with this paragraph.
4. This provision shall not be applicable to service Contracts usually and customarily entered into by Contractor to obtain or arrange for supplies, technical support, and professional services provided by consultants.

D. Contractor shall notify County in writing of any change in the Contractor's status with respect to name changes that do not require an assignment of the Contract. Contractor is also obligated to notify County in writing if the Contractor becomes a party to any litigation against County, or a party to litigation that may reasonably affect the Contractor's performance under the Contract, as well as any potential conflicts of interest between Contractor and County that may arise prior to or during the period of Contract performance. While Contractor will be required to provide this information without prompting from County any time there is a change in Contractor's name, conflict of interest or litigation status, Contractor must also provide an update to County of its status in these areas whenever requested by County.

9. DISPUTE RESOLUTION

A. The Parties shall deal in good faith and attempt to resolve potential disputes informally. If the dispute concerning a question of fact arising under the terms of this Contract is not disposed of in a reasonable period of time by the Contractor and the Administrator, such matter shall be brought to the attention of the County Purchasing

Agency by way of the following process:

1. Contractor shall submit to the County Purchasing Agency a written demand for a final decision regarding the disposition of any dispute between the Parties arising under, related to, or involving this Contract, unless County, on its own initiative, has already rendered such a final decision.
2. Contractor's written demand shall be fully supported by factual information, and, if such demand involves a cost adjustment to the Contract, Contractor shall include with the demand a written statement signed by an authorized representative indicating that the demand is made in good faith, that the supporting data are accurate and complete, and that the amount requested accurately reflects the Contract adjustment for which Contractor believes County is liable.

B. Pending the final resolution of any dispute arising under, related to, or involving this Contract, Contractor agrees to proceed diligently with the performance of services secured via this Contract, including the delivery of goods and/or provision of services. Contractor's failure to proceed diligently shall be considered a material breach of this Contract.

C. Any final decision of County shall be expressly identified as such, shall be in writing, and shall be signed by a County Deputy Purchasing Agent or designee. If County fails to render a decision within ninety (90) calendar days after receipt of Contractor's demand, it shall be deemed a final decision adverse to Contractor's contentions.

D. This Contract 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 Contract, 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 adjudication to another county.

10. EMPLOYEE ELIGIBILITY VERIFICATION

Contractor attests that it shall fully comply with all federal and state statutes and regulations regarding the employment of aliens and others and to ensure that employees, subcontractors, and consultants performing work under this Contract meet the citizenship or alien status requirements set forth in federal statutes and regulations. Contractor shall obtain, from all employees, subcontractors, and consultants performing work hereunder, all verification and other documentation of employment eligibility status required by federal or state statutes and regulations including, but not limited to, the Immigration Reform and Control Act of 1986, 8 USC §1324 et seq., as they currently exist and as they may be hereafter amended. Contractor shall retain all such documentation for all covered employees, subcontractors, and consultants for the period prescribed by the law.

11. EQUIPMENT

A. Unless otherwise specified in writing by Administrator, Equipment is defined as all property of a Relatively Permanent nature with significant value, purchased in whole or in part by Administrator to assist in performing the services described in this Contract. "Relatively Permanent" is defined as having a useful life of one (1) year or longer. Equipment which costs $5,000 or over, including freight charges, sales taxes, and other taxes, and installation costs are defined as Capital Assets. Equipment which costs between $600 and $5,000, including freight charges, sales taxes and other taxes, and installation costs, or electronic equipment that costs less than $600 but may contained PHI or PII, are defined as Controlled Equipment. Controlled Equipment includes, but is not limited to phones, tablets, audio/visual equipment, computer equipment, and lab equipment. The cost of Equipment purchased, in whole or in part, with funds paid pursuant to this Contract shall be depreciated according to GAAP.

B. Contractor shall obtain Administrator's written approval prior to purchase of any Equipment with funds paid pursuant to this Contract. Upon delivery of Equipment, Contractor shall forward to Administrator, copies of the purchase order, receipt, and other supporting documentation, which includes delivery date, unit price, tax, shipping and serial numbers. Contractor shall request an applicable asset tag for said Equipment and shall include each purchased asset in an Equipment inventory.

C. Upon Administrator's prior written approval, Contractor may expense to County the cost of the approved Equipment purchased by Contractor. To "expense," in relation to Equipment, means to charge the proportionate cost of Equipment in the fiscal year in which it is purchased. Title of expensed Equipment shall be vested with County.

D. Contractor shall maintain an inventory of all Equipment purchased in whole or in part with funds paid through this Contract, including date of purchase, purchase price, serial number, model and type of Equipment. Such inventory shall be available for review by Administrator, and shall include the original purchase date and price, useful life, and balance of depreciated Equipment cost, if any.

E. Contractor shall cooperate with Administrator in conducting periodic physical inventories of all Equipment. Upon demand by Administrator, Contractor shall return any or all Equipment to County.

F. Contractor must report any loss or theft of Equipment in accordance with the procedure approved by Administrator and the Notices Paragraph of this Contract. In addition, Contractor must complete and submit to Administrator a notification form when items of Equipment are moved from one location to another or returned to County as surplus.

G. Unless this Contract is followed without interruption by another Contract between the Parties for substantially the same type and scope of services, at the termination of this Contract for any cause, Contractor shall return to County all Equipment purchased with funds paid through this Contract.

H. Contractor shall maintain and administer a sound business program for ensuring the proper use, maintenance, repair, protection, insurance, and preservation of County Equipment.

12. EXPENDITURE AND REVENUE REPORT

A. No later than forty-five (45) calendar days following termination of each period or fiscal year of this Contract, Contractor shall submit to Administrator, for informational purposes only, an Expenditure and Revenue Report for the preceding fiscal year, or portion thereof. Such report shall be prepared in accordance with the procedure that is provided by Administrator and GAAP.

B. Contractor may be required to submit periodic Expenditure and Revenue Reports throughout the term of this Contract.

13. FACILITIES, PAYMENTS AND SERVICES

A. Contractor agrees to provide the services, staffing, facilities, and supplies in accordance with this Contract. County shall compensate, and authorize, when applicable, said services. Contractor shall operate continuously throughout the term of this Contract with at least the minimum number and type of staff which meet applicable federal and state requirements, and which are necessary for the provision of the services hereunder.

B. In the event that Contractor is unable to provide the services, staffing, facilities, or supplies as required, Administrator may, at its sole discretion, reduce the Total Maximum Obligation for the appropriate Period as well as the Total Maximum Obligation. The reduction to the Maximum Obligation for the appropriate Period as well as the Total Maximum Obligation shall be in an amount proportionate to the number of days in which Contractor was determined to be unable to provide services, staffing, facilities or supplies.

14. INDEMNIFICATION

Contractor agrees to indemnify, defend with counsel approved in writing by County, and hold County, its elected and appointed officials, officers, employees, agents and those special districts and agencies for 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 Contractor pursuant to this Contract. If judgment is entered against Contractor and County by a court of competent jurisdiction because of the concurrent active negligence of County or County Indemnitees, Contractor and County agree that liability will be apportioned as determined by the court. Neither Party shall request a jury apportionment.

15. INSURANCE

Prior to the provision of services under this Contract, the Contractor agrees to carry all required insurance at Contractor's expense, including all endorsements required herein, necessary to satisfy the County that the insurance provisions of this Contract have been complied with. Contractor agrees to keep such insurance coverage current, provide Certificates of Insurance, and endorsements to the County during the entire term of this Contract.

Contractor shall ensure that all subcontractors performing work on behalf of Contractor pursuant to this Contract shall be covered under Contractor's insurance as an Additional Insured or maintain insurance subject to the same terms and conditions as set forth herein for Contractor. Contractor shall not allow subcontractors to work if subcontractors have less than the level of coverage required by County from Contractor under this Contract. It is the obligation of Contractor to provide notice of the insurance requirements to every subcontractor and to receive proof of insurance prior to allowing any subcontractor to begin work. Such proof of insurance must be maintained by Contractor through the entirety of this Contract for inspection by County representative(s) at any reasonable time.

All self-insured retentions (SIR)'s shall be clearly stated on the Certificate of Insurance. Any SIR in excess of Fifty Thousand Dollars ($50,000) shall specifically be approved by the County's Risk Manager, or designee. The County reserves the right to require current audited financial reports from Contractor. If Contractor is self-insured, Contractor will indemnify the County for any and all claims resulting or arising from Contractor's services in accordance with the indemnity provision stated in this contract.

If the Contractor fails to maintain insurance acceptable to the County for the full term of this Contract, the County may terminate this Contract.

Qualified Insurer

The policy or policies of insurance must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the

most current edition of the Best's Key Rating Guide/Property-Casualty/United States or ambest.com).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, CEO/ Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings.

The policy or policies of insurance maintained by the Contractor shall provide the minimum limits and coverage as set forth below:

Coverage	Minimum Limits
Commercial General Liability	$1,000,000 per occurrence $2,000,000 aggregate
Automobile Liability including coverage for or scheduled, non-owned, and hired vehicles	$1,000,000 combined owned single limit each accident
Workers Compensation	Statutory
Employers Liability Insurance	$1,000,000 per accident or disease
Network Security & Privacy Liability	$1,000,000 per claims-made
Employee Dishonesty	$1,000,000 per occurrence

Increased insurance limits may be satisfied with Excess/Umbrella policies. Excess/Umbrella policies when required must provide Follow Form coverage.

Required Coverage Forms

The Commercial General Liability coverage shall be written on occurrence basis utilizing Insurance Services Office (ISO) form CG 00 01, or a substitute form providing liability coverage at least as broad.

The Business Auto Liability coverage shall be written on ISO form CA 00 01, CA 00 05, CA 0012, CA 00 20, or a substitute form providing coverage at least as broad.

Required Endorsements

The Commercial General Liability policy shall contain the following endorsements, which shall accompany the Certificate of Insurance:

1) An Additional Insured endorsement using ISO form CG 20 26 04 13, or a form at least as broad naming the County of Orange its elected and appointed officials, officers, employees, and agents as Additional Insureds, or provide blanket coverage, which will state As Required by Written Contract.

2) A primary non-contributory endorsement using ISO form CG 20 01 04 13, or a form at least as broad evidencing that the Contractor's insurance is primary, and any insurance or self-insurance maintained by the County shall be excess and non-contributing.

The Workers' Compensation policy shall contain a waiver of subrogation endorsement waiving all rights of subrogation against the ***County of Orange, its elected and appointed officials, officers, employees, and agents*** or provide blanket coverage, which will state ***As Required by Written Contract.***

The Network Security and Privacy Liability policy shall contain the following endorsements which shall accompany the Certificate of Insurance:

1) An Additional Insured endorsement naming the ***County of Orange, its elected and appointed officials, officers, employees, and agents*** as Additional Insureds for its vicarious liability.

2) A primary and non-contributory endorsement evidencing that the Contractor's insurance is primary, and any insurance or self-insurance maintained by the County shall be excess and non-contributing.

All insurance policies required by this Contract shall waive all rights of subrogation against the ***County of Orange, its elected and appointed officials, officers, employees, and agents*** when acting within the scope of their appointment or employment.

The County of Orange shall be the loss payee on the Employee Dishonesty coverage. A Loss Payee endorsement evidencing that the County of Orange is a Loss Payee shall accompany the Certificate of Insurance.

Contractor shall provide thirty (30) days prior written notice to the County of any policy cancellation or non-renewal and ten (10) days prior written notice where cancellation is

due to non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the Contract, upon which the County may suspend or terminate this Contract.

If Contractor's Network Security & Privacy Liability is a "Claims-Made" policy, Contractor shall agree to the following:

1) The retroactive date must be shown and must be before the date of the Contract or the beginning of the Contract services.

2) Insurance must be maintained, and evidence of insurance must be provided for at least three (3) years after expiration or earlier termination of Contract services.

3) If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a retroactive date prior to the effective date of the contract services, Contractor must purchase an extended reporting period for a minimum of three (3) years after expiration of earlier termination of the Contract.

The Commercial General Liability policy shall contain a severability of interests clause also known as a "separation of insureds" clause (standard in the ISO CG 0001 policy).

Insurance certificates should be forwarded to the agency/department address listed on the solicitation.

If the Contractor fails to provide the insurance certificates and endorsements within seven (7) days of notification by CEO/Purchasing or the agency/department purchasing division, award may be made to the next qualified vendor.

County expressly retains the right to require Contractor to increase or decrease insurance of any of the above insurance types throughout the term of this Contract. Any increase or decrease in insurance will be as deemed by County of Orange Risk Manager as appropriate to adequately protect County.

County shall notify Contractor in writing of changes in the insurance requirements. If Contractor does not provide acceptable Certificates of Insurance and endorsements to County incorporating such changes within thirty (30) days of receipt of such notice, this Contract may be in breach without further notice to Contractor, and County shall be entitled to all legal remedies.

The procuring of such required policy or policies of insurance shall not be construed to limit Contractor's liability hereunder nor to fulfill the indemnification provisions and

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requirements of this Contract, nor act in any way to reduce the policy coverage and limits available from the insurer.

16. INSPECTIONS AND AUDITS

A. Administrator, any authorized representative of County, any authorized representative of the State of California, the Secretary of the United States Department of Health and Human Services, the Comptroller General of the United States, or any other of their authorized representatives, shall to the extent permissible under applicable law have access to any books, documents, and records, including but not limited to, financial statements, general ledgers, relevant accounting systems, medical and program participants' (Participant) records, of Contractor that are directly pertinent to this Contract, for the purpose of responding to a beneficiary complaint or conducting an audit, review, evaluation, or examination, or making transcripts during the periods of retention set forth in the Records Management and Maintenance Paragraph of this Contract. Such persons may at all reasonable times inspect or otherwise evaluate the services provided pursuant to this Contract, and the premises in which they are provided.

B. Contractor shall actively participate and cooperate with any person specified in Subparagraph A, above in any evaluation or monitoring of the services provided pursuant to this Contract, and shall provide the above–mentioned persons adequate office space to conduct such evaluation or monitoring.

C. Audit Response

1. Following an audit report, in the event of non–compliance with applicable laws and regulations governing funds provided through this Contract, County may terminate this Contract as provided for in the Termination Paragraph or direct Contractor to immediately implement appropriate corrective action. A CAP shall be submitted to Administrator in writing within thirty (30) calendar days after receiving notice from Administrator.
2. If the audit reveals that money is payable from one Party to the other, that is, reimbursement by Contractor to County, or payment of sums due from County to Contractor, said funds shall be due and payable from one Party to the other within sixty (60) calendar days of receipt of the audit results. If reimbursement is due

from Contractor to County, and such reimbursement is not received within said sixty (60) calendar days, County may, in addition to any other remedies provided by law, reduce any amount owed Contractor by an amount not to exceed the reimbursement due County.

D. Contractor shall retain a licensed certified public accountant, who will prepare and file with Administrator, an annual, independent, organization-wide audit of related expenditures as may be required during the term of this Contract.

E. Contractor shall forward to Administrator a copy of any audit report within fourteen (14) calendar days of receipt. Such audit shall include, but not be limited to, management, financial, programmatic or any other type of audit of Contractor's operations, whether or not the cost of such operation or audit is reimbursed in whole or in part through this Contract.

17. COMPLIANCE WITH LAWS, FUNDING REQUIREMENTS AND LICENSES

A. Contractor represents and warrants that services to be provided under this Contract shall fully comply, at Contractor's expense, with all standards, laws, statutes, restrictions, ordinances, requirements, and regulations (collectively "laws"), including, but not limited to those issued by County in its governmental capacity and all other laws and funding requirements applicable to the services at the time services are provided to and accepted by County. Contractor acknowledges that County is relying on Contractor to ensure such compliance, and pursuant to the requirements of Paragraph 14 above, Contractor agrees that it shall defend, indemnify and hold County and County Indemnitees harmless from all liability, damages, costs and expenses arising from or related to a violation of such laws.

B. Funds provided under this Contract must be used solely for the purposes identified in in this Contract. In accordance with Paragraph 14 above, Contractor agrees to indemnify, defend, and hold harmless the County of Orange for any sums the State or Federal government contends or determines Contractor used in violation of this Contract. Contractor shall immediately return to the County any funds the County or any responsible State or Federal agency, including the Department of Treasury, determines the Contractor has used in a manner that is inconsistent with this Contract or as a result of noncompliance with any appliable regulations or funding

requirements. The provisions of this paragraph shall survive termination of this Contract.

C. Contractor, its officers, agents, employees, affiliates, and subcontractors shall, throughout the term of this Contract, maintain all necessary licenses, permits, approvals, certificates, accreditations, waivers, and exemptions necessary for the provision of the services hereunder and required by the laws, regulations and requirements of the United States, the State of California, County, and all other applicable governmental agencies.

D. Enforcement of Child Support Obligations

1. Contractor certifies it is in full compliance with all applicable federal and State reporting requirements regarding its employees and with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignments and will continue to be in compliance throughout the term of the Contract with the County of Orange. Failure to comply shall constitute a material breach of the Contract and failure to cure such breach within sixty (60) calendar days of notice from the County shall constitute grounds for termination of the Contract.
2. Contractor agrees to furnish to Administrator within thirty (30) calendar days of the award of this Contract:
   a) In the case of an individual Contractor, his/her name, date of birth, social security number, and residence address;
   b) In the case of a Contractor doing business in a form other than as an individual, the name, date of birth, social security number, and residence address of each individual who owns an interest of ten percent (10%) or more in the contracting entity;
3. It is expressly understood that this data will be transmitted to governmental agencies charged with the establishment and enforcement of child support orders, or as permitted by federal and/or state statute.

18. LITERATURE, ADVERTISEMENTS, AND SOCIAL MEDIA

A. County owns all rights to the name, logos, and symbols of County. The use and/or reproduction of County's name, logos, or symbols for any purpose, including

commercial advertisement, promotional purposes, announcements, displays, or press releases, without County's prior written consent is expressly prohibited.

B. Contractor may develop and publish information related to this Contract where all of the following conditions are satisfied:
   1. Administrator provides its written approval of the content and publication of the information at least thirty (30) days prior to Contractor publishing the information, unless a difference timeframe for approval is agreed upon by the Administrator;
   2. Unless directed otherwise by Administrator, the information includes a statement that the program, wholly or in part, is funded through County, State and Federal government funds;
   3. The information does not give the appearance that the County, its officers, employees, or agencies endorse:
      a) any commercial product or service; and,
      b) any product or service provided by Contractor, unless approved in writing by Administrator;
   4. If Contractor uses social media (such as Facebook, Twitter, YouTube or other publicly available social media sites) to publish information related to this Contract, Contractor shall develop social media policies and procedures and have them available to Administrator. Contractor 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 Contract. The policy is available on the Internet at http://www.ocgov.com/gov/ceo/cio/govpolicies.

19. MAXIMUM OBLIGATION

A. The Total Maximum Obligation of County for services provided in accordance with this Contract, and the separate Maximum Obligations for each period under this Contract, are as specified in the Referenced Contract Provisions of this Contract, except as allowed for in Subparagraph B. below.

B. Administrator may amend the Maximum Obligation by an amount not to exceed ten percent (10%) of Period One funding for this Contract.

20. MINIMUM WAGE LAWS

A. Pursuant to the United States of America Fair Labor Standards Act of 1938, as amended, and State of California Labor Code, §1178.5, Contractor shall pay no less than the greater of the federal or California Minimum Wage to all of its officers, agents, employees, affiliates, and subcontractors ("Covered Individuals") that directly or indirectly provide services pursuant to this Contract, in any manner whatsoever. Contractor shall require and verify that all of its Covered Individuals providing services pursuant to this Contract be paid no less than the greater of the federal or California Minimum Wage.

B. Contractor shall comply and verify that its Covered Individuals comply with all other federal and State of California laws for minimum wage, overtime pay, record keeping, and child labor standards pursuant to providing services pursuant to this Contract.

C. Notwithstanding the minimum wage requirements provided for in this clause, Contractor, where applicable, shall comply with the prevailing wage and related requirements, as provided for in accordance with the provisions of Article 2 of Chapter 1, Part 7, Division 2 of the Labor Code of the State of California (§§1770, et seq.), as it now exists or may hereafter be amended.

21. NONDISCRIMINATION

A. Employment

1. During the term of this Contract, Contractor and its Covered Individuals shall not unlawfully discriminate against any employee or applicant for employment because of his/her 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, or military and veteran status. Additionally, during the term of this Contract, Contractor and its Covered Individuals shall require in its subcontracts that subcontractors shall not unlawfully discriminate against any employee or applicant for employment because of his/her 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, or military and veteran status.

2. Contractor and its Covered Individuals shall not discriminate against employees or applicants for employment in the areas of employment, promotion, demotion or transfer; recruitment or recruitment advertising, layoff or termination; rate of pay or other forms of compensation; and selection for training, including apprenticeship.
3. Contractor shall not discriminate between employees with spouses and employees with domestic partners, or discriminate between domestic partners and spouses of those employees, in the provision of benefits.
4. Contractor shall post in conspicuous places, available to employees and applicants for employment, notices from Administrator and/or the United States Equal Employment Opportunity Commission setting forth the provisions of the EOC.
5. All solicitations or advertisements for employees placed by or on behalf of Contractor and/or subcontractor 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, or military and veteran status. Such requirements shall be deemed fulfilled by use of the term EOE.
6. Each labor union or representative of workers with which Contractor and/or subcontractor has a collective bargaining Contract or other contract or understanding must post a notice advising the labor union or workers' representative of the commitments under this Nondiscrimination Paragraph and shall post copies of the notice in conspicuous places, available to employees and applicants for employment.

B. Services, Benefits And Facilities – Contractor and/or subcontractor shall not discriminate in the provision of services, the allocation of benefits, or in the accommodation in facilities 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, or military and veteran status in accordance with Title IX of the

Education Amendments of 1972 as they relate to 20 USC §1681 - §1688; Title VI of the Civil Rights Act of 1964 (42 USC §2000d); the Age Discrimination Act of 1975 (42 USC §6101); Title 9, Division 4, Chapter 6, Article 1 (§10800, et seq.) of the CCR; and Title II of the Genetic Information Nondiscrimination Act of 2008, 42 USC 2000ff, et seq. as applicable, and all other pertinent rules and regulations promulgated pursuant thereto, and as otherwise provided by state law and regulations, as all may now exist or be hereafter amended or changed. For the purpose of this Nondiscrimination paragraph, discrimination includes, but is not limited to the following based on one or more of the factors identified above:

1. Denying a Participant or potential Participant any service, benefit, or accommodation.
2. Providing any service or benefit to a Participant which is different or is provided in a different manner or at a different time from that provided to other Participants.
3. Restricting a Participant in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service and/or benefit.
4. Treating a Participant differently from others in satisfying any admission requirement or condition, or eligibility requirement or condition, which individuals must meet in order to be provided any service and/or benefit.
5. Assignment of times or places for the provision of services.

C. Complaint Process – Contractor shall establish procedures for advising all Participants through a written statement that Contractor's and/or subcontractor's Participants may file all complaints alleging discrimination in the delivery of services with Contractor, subcontractor, and Administrator.

1. Whenever possible, problems shall be resolved informally and at the point of service. Contractor shall establish an internal informal problem resolution process for Participants not able to resolve such problems at the point of service. Participants may initiate a grievance or complaint directly with Contractor either orally or in writing.
2. Within the time limits procedurally imposed, the complainant shall be notified in writing as to the findings regarding the alleged complaint and, if not satisfied with the decision, may file an appeal.

D. Persons with Disabilities – Contractor and/or subcontractor agree to comply with the provisions of §504 of the Rehabilitation Act of 1973, as amended, (29 USC 794 et seq., as implemented in 45 CFR 84.1 et seq.), and the Americans with Disabilities Act of 1990 as amended (42 USC 12101 et seq.; as implemented in 29 CFR 1630), as applicable, pertaining to the prohibition of discrimination against qualified persons with disabilities in all programs or activities, and if applicable, as implemented in Title 45, CFR, §84.1 et seq., as they exist now or may be hereafter amended together with succeeding legislation.

E. Retaliation – Neither Contractor nor subcontractor, nor its employees or agents shall intimidate, coerce or take adverse action against any person for the purpose of interfering with rights secured by federal or state laws, or because such person has filed a complaint, certified, assisted or otherwise participated in an investigation, proceeding, hearing or any other activity undertaken to enforce rights secured by federal or state law.

F. In the event of non-compliance with this paragraph or as otherwise provided by federal and state law, this Contract may be canceled, terminated or suspended in whole or in part and Contractor or subcontractor may be declared ineligible for further contracts involving federal, state or County funds.

22. NOTICES

A. Unless otherwise specified, all notices, claims, correspondence, reports and/or statements authorized or required by this Contract shall be effective:

1. When written and deposited in the United States mail, first class postage prepaid and addressed as specified in the Referenced Contract Provisions of this Contract or as otherwise directed by Administrator;
2. When faxed, transmission confirmed;
3. When sent by e-mail; or
4. When accepted by U.S. Postal Service Express Mail, Federal Express, United Parcel Service, or any other expedited delivery service.

B. Termination Notices shall be addressed as specified in the Referenced Contract Provisions of this Contract or as otherwise directed by Administrator and shall be

effective when faxed, transmission confirmed, or when accepted by U.S. Postal Service Express Mail, Federal Express, United Parcel Service, or any other expedited delivery service.

C. Contractor shall notify Administrator, in writing, within twenty-four (24) hours of becoming aware of any occurrence of a serious nature, which may expose County to liability. Such occurrences shall include, but not be limited to, accidents, injuries, or acts of negligence, or loss or damage to any County property in possession of Contractor.

D. For purposes of this Contract, any notice to be provided by County may be given by Administrator.

23. NOTIFICATION OF DEATH

A. Upon becoming aware of the death of any person served pursuant to this Contract, Contractor shall immediately notify Administrator.

B. All Notifications of Death provided to Administrator by Contractor shall contain the name of the deceased, the date and time of death, the nature and circumstances of the death, and the name(s) of Contractor's officers or employees with knowledge of the incident.

1. Telephone Notification – Contractor shall notify Administrator by telephone immediately upon becoming aware of the death due to non-terminal illness of any person served pursuant to this Contract; notice need only be given during normal business hours.
2. Written Notification
   a) Non-Terminal Illness – Contractor shall hand deliver, fax, and/or send via encrypted email to Administrator a written report within twenty-four (24) hours after becoming aware of the death due to non-terminal illness of any person served pursuant to this Contract.
   b) Terminal Illness – Contractor shall notify Administrator by written report hand delivered, faxed, sent via encrypted email, within forty-eight (48) hours of becoming aware of the death due to terminal illness of any person served pursuant to this Contract.

c) When notification via encrypted email is not possible or practical Contractor may hand deliver or fax to a known number said notification.

C. If there are any questions regarding the cause of death of any person served pursuant to this Contract who was diagnosed with a terminal illness, or if there are any unusual circumstances related to the death, Contractor shall immediately notify Administrator in accordance with this Notification of Death Paragraph.

24. NOTIFICATION OF PUBLIC EVENTS AND MEETINGS

A. Contractor shall notify Administrator of any public event or meeting funded in whole or in part by the County, except for those events or meetings that are intended solely to serve Participants or occur in the normal course of business.

B. Contractor shall notify Administrator at least thirty (30) business days in advance of any applicable public event or meeting. The notification must include the date, time, duration, location and purpose of the public event or meeting. Any promotional materials or event related flyers must be approved by Administrator prior to distribution.

25. RECORDS MANAGEMENT AND MAINTENANCE

A. Contractor, its officers, agents, employees and subcontractors shall, throughout the term of this Contract, prepare, maintain and manage records appropriate to the services provided and in accordance with this Contract and all applicable requirements.

1. Contractor shall maintain records that are adequate to substantiate the services for which claims are submitted for reimbursement under this Contract and the charges thereto. Such records shall include, but not be limited to, individual patient charts and utilization review records.

B. Contractor shall implement and maintain administrative, technical and physical safeguards to ensure the privacy of PHI and prevent the intentional or unintentional use or disclosure of PHI in violation of the HIPAA, federal and state regulations. Contractor shall mitigate to the extent practicable, the known harmful effect of any use or disclosure of PHI made in violation of federal or state regulations and/or

County policies.

C. Contractor's participant and/or patient records shall be maintained in a secure manner. Contractor shall maintain participant and/or patient records and must establish and implement written record management procedures.

D. Contractor shall retain all financial records for a minimum of ten (10) years from the termination of the contract, unless a longer period is required due to legal proceedings such as litigations and/or settlement of claims.

E. Contractor shall retain all participant and/or patient medical records for ten (10) years following discharge of the participant, participant and/or patient.

F. Contractor shall make records pertaining to the costs of services, participant fees, charges, billings, and revenues available at one (1) location within the limits of the County of Orange. If Contractor is unable to meet the record location criteria above, Administrator may provide written approval to Contractor to maintain records in a single location, identified by Contractor.

G. Contractor shall notify Administrator of any PRA requests related to, or arising out of, this Contract, within forty-eight (48) hours. Contractor shall provide Administrator all information that is requested by the PRA request.

H. Contractor may retain participant, and/or patient documentation electronically in accordance with the terms of this Contract and common business practices. If documentation is retained electronically, Contractor shall, in the event of an audit or site visit:

1. Have documents readily available within twenty-four (24) hour notice of a scheduled audit or site visit.
2. Provide auditor or other authorized individuals access to documents via a computer terminal.
3. Provide auditor or other authorized individuals a hardcopy printout of documents, if requested.

I. Contractor shall ensure compliance with requirements pertaining to the privacy and security of PII and/or PHI. Contractor shall, upon discovery of a Breach of privacy and/or security of PII and/or PHI by Contractor, notify federal and/or state authorities as required by law or regulation, and copy Administrator on such notifications.

J. Contractor may be required to pay any costs associated with a Breach of privacy and/or security of PII and/or PHI, including but not limited to the costs of notification. Contractor shall pay any and all such costs arising out of a Breach of privacy and/or security of PII and/or PHI.

26. RESEARCH AND PUBLICATION

Contractor shall not utilize information and/or data received from County, or arising out of, or developed, as a result of this Contract for the purpose of personal or professional research, or for publication.

27. SEVERABILITY

If a court of competent jurisdiction declares any provision of this Contract or application thereof to any person or circumstances to be invalid or if any provision of this Contract contravenes any federal, state or county statute, ordinance, or regulation, the remaining provisions of this Contract or the application thereof shall remain valid, and the remaining provisions of this Contract shall remain in full force and effect, and to that extent the provisions of this Contract are severable.

28. SPECIAL PROVISIONS

A. Contractor shall not use the funds provided by means of this Contract for the following purposes:

1. Making cash payments to intended recipients of services through this Contract.
2. Lobbying any governmental agency or official. Contractor shall file all certifications and reports in compliance with this requirement pursuant to Title 31, USC, §1352 (e.g., limitation on use of appropriated funds to influence certain federal contracting and financial transactions).
3. Fundraising.
4. Purchase of gifts, meals, entertainment, awards, or other personal expenses for Contractor's staff, volunteers, interns, consultants, subcontractors, and members of the Board of Directors or governing body.
5. Reimbursement of Contractor's members of the Board of Directors or governing

body for expenses or services.

6. Making personal loans to Contractor's staff, volunteers, interns, consultants, subcontractors, and members of the Board of Directors or governing body, or its designee or authorized agent, or making salary advances or giving bonuses to Contractor's staff.
7. Paying an individual salary or compensation for services at a rate in excess of the current Level I of the Executive Salary Schedule as published by the OPM. The OPM Executive Salary Schedule may be found at www.opm.gov.
8. Severance pay for separating employees.
9. Paying rent and/or lease costs for a facility prior to the facility meeting all required building codes and obtaining all necessary building permits for any associated construction.

B. Unless otherwise specified in advance and in writing by Administrator, Contractor shall not use the funds provided by means of this Contract for the following purposes:

1. Funding travel or training (excluding mileage or parking).
2. Making phone calls outside of the local area unless documented to be directly for the purpose of Participant care.
3. Payment for grant writing, consultants, certified public accounting, or legal services.
4. Purchase of artwork or other items that are for decorative purposes and do not directly contribute to the quality of services to be provided pursuant to this Contract.

29. STATUS OF CONTRACTOR

Contractor is, and shall at all times be deemed to be, an independent contractor and shall be wholly responsible for the manner in which it performs the services required of it by the terms of this Contract. Contractor is entirely responsible for compensating staff, subcontractors, and consultants employed by Contractor. This Contract shall not be construed as creating the relationship of employer and employee, or principal and agent, between County and Contractor or any of Contractor's employees, agents, consultants, volunteers, interns, or subcontractors. Contractor assumes exclusively the responsibility

for the acts of its employees, agents, consultants, volunteers, interns, or subcontractors as they relate to the services to be provided during the course and scope of their employment. Contractor, its agents, employees, consultants, volunteers, interns, or subcontractors, shall not be entitled to any rights or privileges of County's employees and shall not be considered in any manner to be County's employees.

30. TAX LIABILITY

Contractor shall report all income and pay all applicable federal, state, and local income taxes or similar levies as a result of any monies paid Contractor pursuant to this Contract. Contractor shall indemnify, defend and hold County harmless from all liability, claims, losses, demands, including defense costs and attorney fees, whether resulting from court action or otherwise, in the event that any taxing authority or other agency attempts to obtain from County any such monies, penalties, and/or interest imposed resulting from any failure of Contractor to comply with the provisions of this paragraph.

31. TERM

A. The term of this Contract shall commence as specified in the Referenced Contract Provisions of this Contract or the execution date, whichever is later. This Contract shall terminate as specified in the Referenced Contract Provisions of this Contract unless otherwise sooner terminated as provided in this Contract. Contractor shall be obligated to perform such duties as would normally extend beyond this term, including but not limited to, obligations with respect to confidentiality, indemnification, audits, reporting, and accounting.

B. Any administrative duty or obligation to be performed pursuant to this Contract on a weekend or holiday may be performed on the next regular business day.

32. TERMINATION

A. Contractor shall be responsible for meeting all programmatic and administrative contracted objectives and requirements as indicated in this Contract. Contractor shall be subject to the issuance of a CAP for the failure to perform to the level of contracted objectives, continuing to not meet goals and expectations, and/or for non-compliance.

If CAPs are not completed within timeframe as determined by Administrator notice, payments may be reduced or withheld until CAP is resolved and/or the Contract could be terminated.

B. County may terminate this Contract immediately, upon written notice, on the occurrence of any of the following events:
   1. The loss by Contractor of legal capacity.
   2. Cessation of services.
   3. The delegation or assignment of Contractor's services, operation or administration to another entity without the prior written consent of County.
   4. The neglect by any physician or licensed person employed by Contractor of any duty required pursuant to this Contract.
   5. The loss of accreditation or any license required by the Licenses and Laws Paragraph of this Contract.
   6. The continued incapacity of any physician or licensed person to perform duties required pursuant to this Contract.
   7. Unethical conduct or malpractice by any physician or licensed person providing services pursuant to this Contract; provided, however, County may waive this option if Contractor removes such physician or licensed person from serving persons treated or assisted pursuant to this Contract.
   8. Any breach of Contract, or any misrepresentation or fraud on the part of the Contractor.

C. Contingent Funding
   1. Any obligation of County under this Contract is contingent upon the following:
      a) The continued availability of federal, state and county funds for reimbursement of County's expenditures, and
      b) Inclusion of sufficient funding for the services hereunder in the applicable budget(s) approved by the Board of Supervisors.
   2. In the event such funding is subsequently reduced or terminated, County may suspend, terminate or renegotiate this Contract upon thirty (30) calendar days' written notice given Contractor. If County elects to renegotiate this Contract due to reduced or terminated funding, Contractor shall not be obligated to accept the

renegotiated terms.

D. In the event this Contract is suspended or terminated prior to the completion of the term as specified in the Referenced Contract Provisions of this Contract, Administrator may, at its sole discretion, reduce the Not To Exceed Amount of this Contract to be consistent with the reduced term of the Contract.

E. In the event this Contract is terminated Contractor shall do the following:

1. Comply with termination instructions provided by Administrator in a manner which is consistent with recognized standards of quality care and prudent business practice.
2. Obtain immediate clarification from Administrator of any unsettled issues of contract performance during the remaining contract term.
3. Until the date of termination, continue to provide the same level of service required by this Contract.
4. If Participants are to be transferred to another facility for services, furnish Administrator, upon request, all Participant information and records deemed necessary by Administrator to effect an orderly transfer.
5. Assist Administrator in effecting the transfer of Participants in a manner consistent with Participant's best interests.
6. If records are to be transferred to County, pack and label such records in accordance with directions provided by Administrator.
7. Return to County, in the manner indicated by Administrator, any equipment and supplies purchased with funds provided by County.
8. To the extent services are terminated, cancel outstanding commitments covering the procurement of materials, supplies, equipment, and miscellaneous items, as well as outstanding commitments which relate to personal services. With respect to these canceled commitments, Contractor shall submit a written plan for settlement of all outstanding liabilities and all claims arising out of such cancellation of commitment which shall be subject to written approval of Administrator.
9. Provide written notice of termination of services to each Participant being served under this Contract, within fifteen (15) calendar days of receipt of termination

notice. A copy of the notice of termination of services must also be provided to Administrator within the fifteen (15) calendars day period.

F. County may terminate this Contract, without cause, upon thirty (30) calendar days' written notice. The rights and remedies of County provided in this Termination Paragraph shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

33. THIRD PARTY BENEFICIARY

Neither Party hereto intends that this Contract shall create rights hereunder in third parties including, but not limited to, any subcontractors or any Participants provided services pursuant to this Contract.

34. WAIVER OF DEFAULT OR BREACH

Waiver by County of any default by Contractor shall not be considered a waiver of any subsequent default. Waiver by County of any breach by Contractor of any provision of this Contract shall not be considered a waiver of any subsequent breach. Waiver by County of any default or any breach by Contractor shall not be considered a modification of the terms of this Contract.

35. DRUG-FREE WORKPLACE

A. The Contractor hereby certifies compliance with Government Code Section 8355 in matters relating to providing a drug-free workplace. The Contractor will:

1. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations, as required by Government Code Section 8355(a)(1).
2. Establish a drug-free awareness program as required by Government Code Section 8355(a)(2) to inform employees about all of the following:
   a. The dangers of drug abuse in the workplace;
   b. The organization's policy of maintaining a drug-free workplace;

c. Any available counseling, rehabilitation and employee assistance programs; and

d. Penalties that may be imposed upon employees for drug abuse violations.

3. Provide as required by Government Code Section 8355(a)(3) that every employee who works under this Contract:

a. Will receive a copy of the company's drug-free policy statement; and

b. Will agree to abide by the terms of the company's statement as a condition of employment under this Contract.

B. Failure to comply with these requirements may result in suspension of payments under the Contract or termination of the Contract or both, and the Contractor may be ineligible for award of any future County contracts if the County determines that any of the following has occurred:

1. The Contractor has made false certification, or

2. The Contractor violates the certification by failing to carry out the requirements as noted above.

SIGNATURE PAGE

IN WITNESS WHEREOF, the Parties have executed this Contract, in the County of Orange, State of California.

Orange County's United Way dba Orange County United Way, a California Nonprofit Corporation

BY: Signed by: Susan Parks F2ABBE2A335E480... DATED: 8/10/2024

TITLE: President & Chief Executive Officer

BY: DocuSigned by: Emilee Tello DAA4A4D855C4427... DATED: 8/12/2024

TITLE: Chief Financial Officer

COUNTY OF ORANGE, a political subdivision of the State of California

BY: DocuSigned by: Christina Rojas 318ECC6B612644D... DATED: 8/12/2024

Deputy Purchasing Agent

APPROVED AS TO FORM
OFFICE OF THE COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

BY: DocuSigned by: Chris Anderson FD52599179CA41C... DATED: 8/12/2024

Deputy

* If the contracting party is a corporation, (2) two signatures are required: one (1) signature by the Chairman of the Board, the President or any Vice President; and one (1) signature by the Secretary, any Assistant Secretary, the Chief Financial Officer or any Assistant Treasurer. The signature of one person alone is sufficient to bind a corporation, as long as he or she holds corporate offices in each of the two categories described above. For County purposes, proof of such dual office holding will be satisfied by having the individual sign the instrument twice, each time indicating his or her office that qualifies under the above described provision. In the alternative, a single corporate signature is acceptable when accompanied by a corporate resolution demonstrating the legal authority of the signee to bind the corporation.

ATTACHMENT A

I. COMMON TERMS AND DEFINITIONS

A. The parties agree to the following terms and definitions, and to those terms and definitions which, for convenience, are set forth elsewhere in the Contract.

1. Access Point means the point of entry into the CES for households experiencing homelessness or at-risk of homelessness.
2. Admission means documentation, by Contractor, of completion of the entry and program enrollment into HMIS.
3. Care Plus Program (CPP) means a comprehensive approach to service delivery for Orange County's most vulnerable Participants. It offers enhanced care coordination, aiming to expedite supportive service linkages quickly and efficiently, by connecting Participants to the most appropriate services and resources across behavioral health, corrections, healthcare, housing and homelessness, and benefits and supportive services.
4. Case Management means a process of identification, assessment of need, planning coordination and linking, monitoring and continuous evaluation of Participants and of available resources activities include the provision of care coordination intended to help participants navigate and address barriers to housing and disability benefits.
5. CES means Coordinated Entry System and refers to the mechanism for allocating available housing units into a systemic resource targeting process designed to implement localized priorities for program Participants. The CES covers the geographic area of Orange County and is regionally focused by Service Planning Areas, is easily accessed by individuals and families seeking housing and services and includes a comprehensive and standardized process used by all service providers in the Orange County System of Care.
6. CES Community Queue means a list of eligible Participants generated from a standardized assessment. The CES Community Queue is used to refer households to shelter and permanent housing programs, including rapid rehousing and

permanent supportive housing, in Orange County.

7. Participant means an individual, referred by County or enrolled in Contractor's program for services under the Contract, who is experiencing homelessness in Orange County.
8. CoC means Continuum of Care, a regional or local planning body that coordinates housing and services funding for homeless families and individuals. The CoC strategizes the community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximize self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness.
9. Critical Time Intervention (CTI) is a time-limited, focused approach designed to support people as they transition into housing from homelessness. CTI is carried out in three distinct phases spanning nine months: Transition, Try-Out and Transfer of Care.
10. Cultural Competency means consideration for cultural and linguistic factors in addressing the needs of populations to be served. Subpopulation identities may include, but are not limited to, race and ethnicity, gender and gender identity, sexual orientation, economic class, age, family status, language spoken and understood, physical and mental disabilities, living situation, etc. The Program must have the capacity to accommodate special populations within the general population (i.e., youth, LGBTQIA, Participants with disabilities, veterans, victims of domestic violence) throughout all levels of the organization, from organizational vision and mission statement to policy implementation, and to service delivery procedures and philosophies.
11. Data Collection System means software designed for collection, tracking and reporting outcomes data for Participants enrolled in the Homeless Service Programs. The primary data collection system utilized is the Homeless Management Information System (HMIS); however, victim service providers utilize comparable Data Collection Systems.
12. Engagement means the process by which a trusting relationship between worker and Participant(s) is established with the goal to link the individual(s) to the

appropriate services, including street outreach, emergency shelter and housing programs. Engagement of Participant(s) is the objective of a successful Outreach.

13. Family means household with at least one minor child and one adult over the age of 18, household with an expectant mother, or household that are working towards reunification with minor children referred by the County or any other referral partner.
14. Harm Reduction Approach means the policies, procedures, and practices that aim to reduce the negative consequences of behaviors that are detrimental to the Participant's health and well-being (i.e., abuse of drugs and/or alcohol, failure to be medication compliant, engaging in criminal activity, choosing to sleep outside, etc.). In shelter settings, harm reduction is intended to prevent a Participant's termination from the program based solely on his or her inability to stop engaging in harmful behaviors.
15. Housing Assistance refers to assisting participants in finding and securing interim and permanent housing, maintaining current housing, and stabilizing new housing.
16. Homeless Management Information System (HMIS) refers to a database mandated by the U.S. Department of Housing and Urban Development used to collect participant-level data on the provision of housing and supportive services to individuals and families at risk of homelessness or experiencing homelessness.
17. Housing First Principles include access to a homeless service program is not contingent on sobriety, minimum income requirements, lack of a criminal record, completion of treatment, participation in services, or other unnecessary conditions; support services are available but are voluntary, participant-driven, individualized, and flexible; and services are informed by a harm-reduction philosophy that recognizes that drug and alcohol use are a part of some participants' lives. Participants are engaged in nonjudgmental communication regarding drug and alcohol use and are offered education regarding how to avoid risky behaviors and engage in safer practices.
18. Housing Navigation is community-based, solution-focused strategy that assists participants with complex and frequent occurring issues that prevent them from

accessing and maintaining stable housing.

19. Housing Specialist means a specialized position dedicated to developing the full array of housing options for their program and monitoring their sustainability for the population served in accordance with the minimal housing standards policy set by County for their program. The Housing Specialist is also responsible for assisting Participants with applications to low-income housing, housing subsidies, senior housing, etc.
20. Individuals refers to adults aged 18 and older. Individuals may be single person households and adult-only households.
21. Information and Referrals refers to the provision of information on community, social, health and government programs in the community that address the needs of Participants. This may include information to access community health clinics, food pantries, support groups, etc.
22. Intake means the initial meeting between a Participant and Contractor's staff and includes an evaluation to determine if the Participant meets program criteria and is willing to seek services.
23. Lived Experienced Advisory Committee (LEAC) refers to the CoC Committee made up of individuals with current and/or past lived experience of homelessness, created to function in an advisory capacity to the CoC Board, ensure that the voices and perspectives of persons with current and/or past lived experience of homelessness are heard and considered in the decision-making process of the Orange County CoC and provide a way to share recommendations and feedback on the CoC Board and the programs and services.
24. Low Barrier Approach means the utilization of practices to reduce barriers to a Participants' program entry, which may include, but is not limited to, reducing barriers to allowing for pets, possessions, and privacy within the Program.
25. Motivational Interviewing means an evidence-based practice that is a directive, Participants-centered counseling style for eliciting behavior change by helping Participants to explore and resolve ambivalence.
26. Outreach means the outreach to potential Participants to link them to appropriate supportive services and may include activities that involve educating the

community about the services offered and requirements for participant in the programs. Such activities should result in Contractor developing its own Participant referral sources for the programs it offers.

27. Participants refers to eligible households served by the program.
28. Persons with Lived Experience refers to individuals who have current and/or past lived experience of homelessness in Orange County.
29. Program Director means an individual who has complete responsibility for the day-to-day function of the program. The Program Director is the highest level of decision-making at a local, program level.
30. Referral means providing the effective linkage of a Participant to another service, when indicated; with follow-up to be provided within five (5) working days to assure that the Participant has made contact with the referred service.
31. Service Planning Areas (SPA): The three geographic areas of Orange County (North, Central, and South) designated for the purposes of promoting increased coordination and collaboration in the delivery of programs and solutions that effectively address homelessness. Reference Attachment A for map of the Orange County SPAs.
32. System of Care Data Integration System (SOCDIS) means a project that integrated nine databases, creating one Virtual Participant Record with a Participant's demographics, program history and service utilization. Interdepartmental data and information sharing is facilitated by a Multi-Disciplinary Team (MDT) that meets twice a month to coordinate care for high utilizers accessing County services/programs.
33. "Transitional Aged Youth (TAY)" refers to individuals age 24 or younger at program entry. Transitional Aged Youth may also include unaccompanied youth, and parenting youth households whose head of households and all household members are 24 or younger.
34. Trauma-Informed Care requires that every part of the Program's design and operation be approached with an understanding of trauma and the impact it has on those receiving services.
35. U.S. Department of Housing and Urban Development (HUD) means one of the

executive departments of the United States Federal Government that is tasked with federal housing and urban development laws and administering of related programs and services.

B. Contractor and Administrator may mutually agree, in writing, to modify the Common Terms and Definitions Paragraph of this Exhibit A to the Agreement.

II. BUDGET

A. County shall pay Contractor in accordance with the Payments Paragraph of this Attachment A to the Contract and the following budget, which is set forth for informational purposes only and may be adjusted by mutual agreement, in writing, by Administrator and Contractor. The total of such payments shall not exceed the Maximum Obligation as specified in the Referenced Contract Provisions of the Contract.

1. Contract Period 1: August 12, 2024 – August 11, 2025

ADMINISTRATIVE COSTS	**FY 24-25 BUDGET**	**FY 24-25 Leveraged Funds**
Salaries	$0	$0
Benefits	$0	$0
Services and Supplies	$0	$0
Professional Services Costs	$0	$0
Indirect	$150,000	$0
TOTAL ADMINISTRATIVE COST	**$150,000**	**$0**
PROGRAM COSTS		
Salaries	$47,257.60	$47,257.60
Benefits	$9,451.54	$9,451.54
Services and Supplies	$989,936.00	$146,934.00
Subcontractor Costs	$303,354.48	$115,248.17
Flexible Funds	$0	$0
Start-Up Funds	$0	$0
TOTAL PROGRAM COSTS	**$1,349,999.62**	**$318,891.31**
TOTAL COSTS	**$1,499,999.62**	**$318,891.31**

2. Contract Period 2: August 12, 2025 – August 11, 2026

ADMINISTRATIVE COSTS	**FY 25-26 BUDGET**	**FY 26-26 Leveraged Funds**
Salaries	$0	$0

Benefits	$0	$0
Services and Supplies	$0	$0
Professional Services Costs	$0	$0
Indirect	$150,000	$0
TOTAL ADMINISTRATIVE COST	**$150,000**	**$0**
PROGRAM COSTS		
Salaries	$47,257.60	$47,257.60
Benefits	$9,451.54	$9,451.54
Services and Supplies	$984,247.00	$136,077.00
Subcontractor Costs	$309,043.90	$118,295.19
Flexible Funds	$0	$0
Start-Up Funds	$0	$0
TOTAL PROGRAM COST	**$1,350,000.05**	**$311,081.34**
TOTAL COSTS	**$1,500,000.05**	**$311,081.34**

B. Budget/Staffing Modifications – Contractor may request to shift funds between budgeted line items, for the purpose of meeting specific program needs or for providing continuity of care to its members, by utilizing a Budget/Staffing Modification Request form provided by Administrator. Contractor shall submit a properly completed Budget/Staffing Modification Request to Administrator for consideration, in advance, which shall include a justification narrative specifying the purpose of the request, the amount of said funds to be shifted, and the sustaining annual impact of the shift as may be applicable to the current contract period and/or future contract periods. Contractor shall obtain written approval of any Budget/Staffing Modification Request(s) from Administrator prior to implementation by Contractor. Failure of Contractor to obtain written approval from Administrator for any proposed Budget/Staffing Modification Request(s) may result in disallowance of those costs.

C. Financial Records – Contractor shall prepare and maintain accurate and complete financial records of its cost and operating expenses. Such records will reflect the actual cost of the type of service for which payment is claimed. Any apportionment of or distribution of costs, including indirect costs, to or between programs or cost centers of Contractor shall be documented, and will be made in accordance with GAAP.

D. Contractor and Administrator may mutually agree, in writing, to modify the Budget Paragraph of this Exhibit A to the Agreement.

III. PAYMENTS

A. County shall pay Contractor monthly, in arrears. All payments are interim payments only, and subject to Final Settlement in accordance with the Cost Report Paragraph of the Agreement for which Contractor shall be reimbursed for the actual cost of providing the services hereunder; provided, however, the total of such payments do not exceed the Maximum Obligation as specified in the Referenced Contract Provisions of the Agreement, and provided further, Contractor's costs are reimbursable pursuant to County, state, and federal regulations. Administrator may, at its discretion, pay supplemental invoices for any month for which the provisional amount specified above has not been fully paid.

1. In support of the monthly invoices, Contractor shall submit an Expenditure and Revenue Report as specified in the Reports Paragraph of this Attachment A to the Contract. Administrator shall use the Expenditure and Revenue Report to determine payment to Contractor as specified in Subparagraphs A.2. and A.3., below.
2. If, at any time, Contractor's Expenditure and Revenue Reports indicate that the provisional amount payments exceed the actual cost of providing services, Administrator may reduce County payments to Contractor by an amount not to exceed the difference between the year-to-date provisional amount payments to Contractor's and the year-to-date actual cost incurred by Contractor.
3. If, at any time, Contractor's Expenditure and Revenue Reports indicate that the provisional amount payments are less than the actual cost of providing services, Administrator may authorize an increase in the provisional amount payment to Contractor by an amount not to exceed the difference between the year-to-date provisional amount payments to Contractor and the year-to-date actual cost incurred by Contractor.

B. Contractor's invoicing shall be on a form approved or supplied by Administrator and provide such information as is required by Administrator. Invoices are due the twentieth (20th) day of each month. Invoices received after the due date may not be paid within the same month. Payments to Contractor should be released by County no later than thirty (30) calendar days after receipt of the correctly completed invoice.

C. All invoices to County shall be supported, at Contractor's facility, by source documentation including, but not limited to, ledgers, journals, time sheets, invoices, bank statements, canceled checks, receipts, receiving records, and records of services provided.

D. Administrator may withhold or delay any payment if Contractor fails to comply with any provision of the Contract.

E. County shall not reimburse Contractor for services provided beyond the expiration and/or termination of the Contract, except as may otherwise be provided under the Contract, or specifically agreed upon in a subsequent agreement.

F. Contractor will have sixty (60) days following the end of each Contract Period to submit outstanding invoices for reimbursement of eligible costs incurred during that Contract Period. After the sixty (60) day period for submitting invoices has expired, County shall reallocate the remaining balance under this Contract for other program purposes and Contractor shall be ineligible for any further reimbursement.

G. Contractor and Administrator may mutually agree, in writing, to modify the Payments Paragraph of this Attachment A to the Contract.

IV. REPORTS

A. Contractor shall maintain records and make statistical reports as required by Administrator.

B. Fiscal

1. Contractor shall submit monthly Expenditure and Revenue Reports to Administrator. These reports will be on a form acceptable to, or provided by, Administrator and will report actual costs and revenues for Contractor 's program described in the Services Paragraph of this Attachment A to the Contract. The reports will be received by Administrator no later than the twentieth (20th) day following the end of the month being reported. Contractor must request in writing any extensions to the due date of the monthly required reports. If an extension is approved by Administrator, the total extension will not exceed more than five (5) calendar days.
2. Contractor shall submit monthly Year-End Projection Reports to Administrator.

These reports will be on a form acceptable to, or provided by, Administrator and will report anticipated year-end actual costs and revenues for Contractor's Program described in the Services Paragraph of this Attachment A to the Contract. Such reports will include actual monthly costs and revenue to date and anticipated monthly costs and revenue to the end of the fiscal year. Year-End Projection Reports will be submitted in conjunction with the Monthly Expenditure and Revenue Reports.

C. Staffing – Contractor shall submit monthly Staffing Reports to Administrator. These reports will be on a form acceptable to, or provided by, Administrator and will, at a minimum, report the actual FTEs of the positions stipulated in the Staffing Paragraph of this Attachment A to the Contract and will include the employees' names, licensure status, monthly salary, hire and/or termination date and any other pertinent information as may be required by Administrator. The reports will be received by Administrator no later than twentieth (20th) day following the end of the month being reported. If an extension is approved by Administrator, the total extension will not exceed more than five (5) calendar days.

D. Programmatic – Contractor may be required to submit monthly and annual reports to Administrator. These reports shall be on a form acceptable to, or provided by, Administrator. Administrator may request additional Program reports of Contractor in order to determine the quality and nature of services provided hereunder. Administrator will be specific as to the nature of information requested and may allow up to thirty (30) calendar days for Contractor to respond to request.

E. Additional Reports – Contractor shall submit additional reports as reasonably required by Administrator concerning Contractor's activities as they affect the duties and purposes contained in the Contract. Administrator will provide Contractor with at least thirty (30) calendar days' notice if such additional reports are required and shall explain any procedures for reporting the required information.

F. Contractor shall report all special incidents to Administrator and shall submit a written Special Incident Report in accordance with the Notices Paragraph of the Contract. Special incidents shall include, but are not limited to, Participant's suicide or attempted suicide, elopement or absence without leave, serious injury, death, criminal behavior, or any other incident which may expose County or Contractor to liability.

G. Subject to mutual agreement in writing, the Contractor and Administrator may alter the reporting requirements.

V. SERVICES

A. Scope of Services

1. Overview

a. The HPSP Program is an initiative of Supervisor Vicente Sarmiento, Second District, that was unanimously supported by the Board of Supervisors and looks to invest in Homelessness Prevention, the first pillar of the Commission to End Homelessness's Homeless Service System Pillars Report, by targeting households who face imminent eviction and keeping them stably housed. In June 2023, the California Statewide Study of People Experiencing Homelessness report stated that more than 171,000 people in California experience homelessness daily. In order to make meaningful progress in addressing homelessness, a concerted effort is needed to prevent additional households from falling into homelessness. The HPSP Program's goal is to promote stability in the lives of households facing eviction and assist them through direct payments, wrap around services, and case management to keep them housed.

b. The HPSP Program combines homelessness prevention and robust case management aimed at promoting housing stability. Homelessness Prevention is a short-term (no longer than 12-months) financial intervention provided to households made up of individuals or families at risk of homelessness or experiencing a housing crisis. The goal is to achieve housing stability, to pay rental arrears, past due utility bills (electricity, gas, water, and trash), and forward rent and/or utility bills based on financial need. The robust case management focuses on developing financial stability and supportive services plans to identify community-based programs and resources that support the household in achieving housing stability. The expected program enrollment for households will be 12-months, based upon need and evaluated on a quarterly basis.

2. Program Description Summary
    a. The HPSP Program shall operate in accordance with each county district's specific eligibility criteria. All services shall be delivered utilizing evidenced-based practices including trauma-informed care, critical time intervention, and motivational interviewing. When services are subcontracted, Contractor shall ensure that HPSP service components and requirements are adhered to by subcontracted providers.
    b. The following service components are to be provided by HPSP Program:
        i. **Community Outreach:** Contractor shall commit to working with the Office of Care Coordination on an appropriate and effective outreach strategy that may include a customized approach to each district. Contractor shall ensure clear communication regarding each county district's specific eligibility criteria.
            a) Contractor shall develop a mechanism to receive referrals from homeless service providers and community-based organizations, as well as establishing clear timelines for subsequent engagement with potential participants and subsequent assessment and screening. This includes coordinating with referring partners such as the Family Solutions Collaborative (FSC) and Family Shelter Providers (FSP) to directly refer families via the 211OC Connection Line.
        ii. **Application Process:** Contractor shall implement an application process that households must complete to gather the preliminary information needed to confirm eligibility. Contractor shall conduct an assessment to determine the risk that the participant will become homeless without assistance. The program must select and utilize a risk assessment tool that must be approved by the County.
            a) Contractor shall ensure that the 211OC 24/7 contact center's Information and Referral (I&R) Specialist will complete an application process with potential participants and screen for

program eligibility utilizing the risk assessment tool determined by the County.

b) Once Contractor confirms eligibility, the participant will be referred to the appropriate district-specific provider within one business day. Contractor shall ensure a closed-loop referral process.

c) Contractor shall ensure that the assigned service provider will schedule an in-person or by phone appointment within five (5) business days of receiving a referral.

d) Contractor shall ensure that the assigned provider's assigned case manager will collect all necessary documentation to confirm district-specific eligibility.

e) The assigned case manager shall complete a request for financial assistance to United Way through the Whatever it Takes portal.

f) Contractor shall ensure eligibility verification through an established set of mechanisms:

1. Age of head of household: driver's license or CA ID, birth certificate, passport.
2. Individual and household income verification; verify Medi-Cal and income (AMI) eligibility by District.
3. Verification that they live in Orange County, CA, by providing documentation that may include lease, utility bill, phone bill, water bill, driver's license or CA ID, children's school.
4. 3-day Notice to Pay or Quit or other documentation that verifies need for payment (i.e., informal eviction proceedings, past rent due, etc.).
5. District 1, 2, 3, and 5: proof of minor child and child's age in the household (i.e., birth certificate, school records, immunization records, etc.).
6. District 5: proof of employment in hospitality industry (i.e., paystub, W2, letter from employer, etc.).

7. Reference other District-specific eligibility requirements, as needed.

iii. **Case Management**: Contractor shall ensure consistent case management activities for each subcontracted provider. These case management services shall focus on stabilizing participants through non-financial interventions. Case management shall include the provision of care coordination intended to help participants navigate and address barriers to housing stability including connections to employment services, job training, mainstream benefits, healthcare, behavioral health, legal aid, financial literacy services, rental counseling, etc. Through case management, the Contractor, via subcontractors, shall actively integrate supportive services, ensuring that the various components of the HPSP program shall be provided to the participant from the point of referral to housing stability. Contractor, via subcontractors, shall:

a) Incorporate best practices, including regular check-ins and communication, linkages to appropriate supportive services, the tracking of participants' cases, including housing and employment status.

b) Ensure that program staff are available to engage with landlords, enter into negotiations with the landlords, and resolve issues that are arising around past due rent. Contractor, via subcontractors, is responsible for ongoing communication and assisting to resolve any future issues or conflicts that arise between participants and landlords.

c) Begin case management once eligibility has been verified and participant has been accepted by the subcontracted provider agency and continue throughout the program enrollment for up to 12 months.

d) Conduct an assessment to determine the history of participation in other assistance programs and collection of needed

demographic information from participants; shall be able to assess and re-evaluate the participant's service needs and make recommendations to appropriate and eligible housing and/or supportive services that best meet the participants' needs.

e) Ensure that ongoing case management is provided to participants in a field-based capacity and that program staff conduct house visits to where people are living, where possible. Case management services are expected to be provided at a minimum of twice monthly. Contractor shall ensure subcontractors implement a case management ratio of one (1) case manager to every twenty-five (25) participants.

f) Ensure that case managers will receive SparkPoint financial coach training and provide 12 months of financial coaching during biweekly case management meetings.

g) Provide case management that supports participants in creating a budget to understand what budgeting changes and resources are needed to create stability in housing.

h) Create an Individualized Housing and Service Plan for the family, in partnership with the eligible participant, that considers and incorporates the goals of the participant and focuses on maintaining stable housing as well as other life areas that will support and assist participants in successfully obtaining and maintaining housing. The Individualized Housing and Service Plan shall detail a path to housing stability and support the participants in maintaining permanent housing after the assistance ends. The Individualized Housing and Service Plan shall be continuously reassessed during program enrollment to address potential areas that may impact housing stability.

i) Ensure appropriate leveraging and utilization of CalAIM services including Enhanced Care Management (ECM) and Community Supports (CS). Contractor shall prioritize subcontracted partners

that are authorized providers of ECM and CS service. Contractor is responsible for ensuring that CalAIM services are nonduplicative while augmenting the HPSP Program.

j) Have a network of resources where they can provide referrals and linkages to support participants. Networks must at minimum include physical health care, behavioral health care, benefits support, employment services, legal services, credit counseling, and education. Contractor via subcontractors shall establish workflows to refer participants to CalOptima Health for CalAIM services.

k) Record services in the Homelessness Management Information System (HMIS) in accordance with the adopted HMIS Policies and Procedures. This includes timely and appropriate data input in HMIS, including progress notes after each engagement and/or case management session with a participant.

l) Be flexible to accommodate participant needs, included but not limited to operating extended hours and weekends.

m) Ensure that District 4 provider delivers housing specific case management services, including housing navigation, to households experiencing homelessness. If participant is eligible for CalAIM services, Contractor shall refer participant to Community Supports for housing navigation and deposit assistance. If participant is not eligible for CalAIM, the assigned case manager will take the lead on the housing navigation process.

iv. **Financial Disbursement:** Contractor shall provide financial disbursement to participants to support housing stability. Financial assistance is expected to be flexible and individualized to the needs of each participant and will include one or two components – Direct Financial Assistance and Stabilization Payments

a) Contractor shall process payments for rental arrears, past due utility bills, and forward rent and/or utility bills based on financial

need, and as described in the below table. This will require coordination with the needed utility companies, landlords and/or property management companies and subcontracted case manager. Direct financial assistance needs should be assessed at program entry and disbursed based on participant needs and program requirements.

b) Contractor shall provide recurring financial allocations of $400, for up to 12 months to support eligible households who are residents of District 2 or 3 and collect information from participants on the use of this funding. The intent is that these direct payments are utilized by participants to cover essential living expenses, such as rent, utilities, and other crucial needs, fostering stability and preventing homelessness for the recipients. However, the use of this funding will not be restricted nor limited.

c) Financial assistance shall be tracked in HMIS.

d) Contractor will ensure subcontractors consult with benefit and tax specialists to ensure that participants understand the impact that stabilization payments may have on their benefits and taxes.

Supervisorial District	**1**	**2**	**3**	**4**	**5**
Maximum Assistance	$5,000	$10,800	$10,800	Three (3) months of assistance or $10,800, whichever amount is greater	$10,800
Direct Financial Assistance –	Yes, up to $5,000.	Yes, up to $6,000.	Yes, up to $6,000.	Yes, up to three months of assistance.	Yes, up to $10,800.

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rental arrears, past due utility bills, and forward rent and/or utility bills based on need, paid directly to landlord and/or utility company.				• Allows for the payment of rental deposits and utility deposits	• Utility bills to include internet access. • Rent may be paid for apartments, houses or mobile homes. • Allows for payment of rental deposits
Stabilization Payment – reoccurring financial payment of $400 directly to participant	No	Yes, maximum amount is $4,800.	Yes, maximum amount is $4,800.	No direct financial payment to participant	No direct financial payment to participant • Will allow for the payment of childcare expenses directly to provider.

v. **Administrative Activities:** Contractor shall meet the following administrative responsibilities:

a) Communication with the County, County Procurement Office (CPO), Office of Care Coordination, and subcontracted partners

involved in the services associated with the program to ensure successful coordination of services.

b) Contractor will communicate and work collaboratively with an academic institution for the purposes of approved research activities.

c) Submit monthly invoicing and required Expense and Revenue (E&R) reporting to the County and CPO staff on the 20th of the following month, after services have been rendered.

d) Utilize the Homeless Management Information System (HMIS) and Whatever it Takes (WIT) portal to complete all data entry and data tracking for the HPSP Program.

e) Submit monthly reporting to the Office of Care Coordination on the operations of the HPSP Program, including but not limited to the following:

i. Outreach activities.

ii. Total number of applications received and reviewed to confirm eligibility.

iii. Number of program enrollments

3. Use of Funds

a. Funds shall be used to provide contracted services and operations of the Program. The Program and eligible costs have been informed by best practices frameworks focused on ensuring those individuals maintain their permanent housing.

b. The Program shall be administered in an equitable manner by providing culturally responsive and linguistically appropriate services and having multicultural Program staff to engage and guide underserved participants throughout the housing process. Program staff shall operate in accordance with non-discrimination policies and attend annual trainings that focus on understanding implicit biases and cultural sensitivities to promote diversity and equity within the Program. Services shall be responsive to the unique needs of

the subpopulation receiving assistance, including seniors, single parent households, and populations disproportionately impacted by housing insecurity.

c. The Program shall also promote connections to service providers, increased housing stability and increased access to benefits and employment resources as needed. Services and operations shall be low-barrier and promote an engagement rich environment in which Participants make connections to supportive services and maintain stable housing.

4. Target Population and Eligibility Requirements
   a. HPSP services shall be provided to:
      i. Head of household(s) who are age 18 and older,
      ii. Orange County Resident, as is confirmed via documents such as utility bills, lease agreements, child's school, etc.
      iii. At risk of homelessness as defined by:
         a) An individual or family who does not have sufficient resources immediately available to prevent them from moving to an emergency shelter or another place not meant for human habitation; and
         b) Meets one of the following conditions:
            i. Currently in formal eviction proceedings; or
            ii. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance.
   b. Additional eligibility criteria are applied based on the Supervisorial District that the participant's residential address is located in. Contractor shall ensure that program staff utilize the Find My District look up tool to ensure that each participant's district is correctly identified, and the appropriate eligibility criteria is applied.
   c. Supervisorial District 1 Additional Eligibility Criteria:
      i. Participant must be eligible for Medi-Cal and;
      ii. Total household income at or below 30% Area Median Income and;
      iii. Family households must have at least one minor child and;
      iv. Participant must demonstrate the ability to pay future and ongoing rent

d. Supervisorial District 2 Additional Eligibility Criteria:
   i. Participant must be eligible for Medi-Cal and;
   ii. Total household income at or below 30% Area Median Income and one of the following:
   iii. Head of household must be a senior, age 60 and older or;
   iv. A single parent household
e. Supervisorial District 3 Additional Eligibility Criteria:
   i. Participant must be eligible for Medi-Cal and;
   ii. Total household income at or below 30% Area Median Income and one of the following:
   iii. Head of household must be a senior, age 60 and older or;
   iv. A single parent household with a minor child
f. Supervisorial District 4 Additional Eligibility Criteria:
   i. Participant does not need to be eligible for Medi-Cal and;
   ii. Total household income at or below 80% Area Median Income and;
   iii. Family households must have at least one minor child and;
   iv. Participant must demonstrate the ability to pay ongoing and future rent
g. Supervisorial District 5 Additional Eligibility Criteria:
   i. Participant does not need to be eligible for Medi-Cal and;
   ii. Total household income at or below 50% Area Median Income and;
   iii. Participant must live in District 5, excluding the Cities of Costa Mesa and Irvine and;
   iv. Participant must be a single parent household with at least one minor child and;
   v. Parent must be employed in the hospitality industry (hotel, motel, and restaurants within hotels and motels)

5. Essential Requirements – Contractor, via subcontractors, shall:
   a. Offer core and flex delivery of services to ensure availability and accessibility for people experiencing homelessness. Hours of operation will be Monday – Friday, 8 am to 5 pm, with flex scheduling offering evening and weekend availability to accommodate Participant preferences and/or County needs. This

approach will augment opportunities to maximize Participant engagement with HPSP services. Staff will be recruited to scheduling and understand that the service will meet the needs of the Participant.

b. Maintain a holiday schedule consistent with County's holiday schedule, unless otherwise approved, in advance and in writing, by Administrator.

c. Operate the program to include flexibilities to meet with eligible Participants outside of typical operation hours, if needed related to conflicts with employment or other appropriate factors.

d. The administrative office of Orange County United Way is located at 18012 Mitchell South, Irvine, CA 92614. Program offices will be provided by subcontracted provider partners and shall provide reasonable accessibility for participants in each Supervisorial District.

e. Have a 24-hour contact available to program staff for emergency purposes and communication policies and procedures in place to notify County as appropriate.

f. Have a 24-hour contact available to County for emergency purposes and to coordinate response as appropriate.

g. Ensure that all Contractor/subcontractor staff and volunteers working in support of the Contract complete training on confidentiality and compliance to ensure appropriate safeguards are in place to maintain Applicant information and PII private, confidential, secure, etc.

6. Administrative Management Tasks – Contractor shall:

a. Work in partnership with County to deliver the services as outlined in the program by being responsive to the needs of the household eligible for services.

b. Submit policies and procedures for the operations of the program, as requested by County for services, management plan, staff responsibilities and staff coordination. The policies and procedures shall note how the program is being administered to ensure there is no duplication of services.

c. Track program costs and ensure eligibility for payment within the funding requirements.

d. Operate, maintain, coordinate and staff the resources of the program, including ensuring each subcontracted partner organization provides case management services focused on each Supervisorial District.

e. Via subcontractors, coordinate with County agencies to provide appropriate supportive services to program Participants including but not limited to HCA, Social Services Agency (SSA), County Executive Office (CEO), and OC Community Resources (OCCR).

f. Coordinate with County agencies, the Orange County CoC and community-based organizations on administrative functions such as operations meetings, as necessary and appropriate. This may incorporate technology solutions such as teleconferencing and videoconferencing and may also include in person meetings.

g. Ensure subcontractors enter program data into HMIS and/or comparable database and adhere to all implementation guidelines developed under the Orange County CoC and per HMIS standards or amended HMIS standards as applicable.

h. Create a comprehensive program compliance plan.

i. Create dashboards and reports on all required performance objectives, including progress toward objectives. Contractor shall monitor performance on a monthly basis.

j. Contractor shall meet with subcontracted provider partners at a minimum on a monthly basis. During these meetings Contractor will provide support, consultation, and discuss performance issues.

k. Contractor shall secure monthly reports from subcontracted partners, which will be consolidated and submitted to County with Contractor's regular reporting.

l. Contractor shall participate in monthly provider meetings with the County to monitor progress.

B. Performance Objectives and Monitoring

1. The following performance objectives will be a requirement of this Contract:

a. Provider shall provide HPSP Services to a minimum of 217 households over the contract term (108 households/year)
   i. A minimum of 19.5 households served annually in District 1
   ii. A minimum of 58 households served annually in District 2
   iii. A minimum of 13 households served annually in District 3
   iv. A minimum of 9 households served annually in District 4
   v. A minimum of 9 households served annually in District 5

b. 71 households per year (142 total) in Districts 2 and 3 will receive Stabilization Payments.

c. At minimum, 75% of participants are able to remain housed twelve (12) months after receiving Direct Financial Assistance without triggering eviction process.

d. Maintain 25 unduplicated, eligible participant household on a caseload per 1 FTE case manager by providing HPSP service. As some participants will not have needs for maximum assistance to achieve housing stability, the total number of households served may increase over the course of the contract.

e. Of the participants enrolled in the program during the reporting period, 80% of participants will have an Individualized Housing and Service Plan within 21 days of program enrollment. This plan must detail identified basic needs to be addressed and plan to support participant in addressing and meeting these basic needs.

f. 75% of participants will receive referrals to other supportive services as identified in the Individualized Housing and Service Plan within the first ninety (90) days.

g. Contractor via subcontractors shall review submitted applications and provide a preliminary determination of eligibility within three (3) business days of application being received.

h. Contactor, via subcontractor, will schedule an in-person and/or telephone appointment with people who have received a preliminary determination of eligibility within five (5) business days of application having been reviewed.

2. County in coordination with Contractor will conduct onsite or virtual visits or desk monitoring to ensure programmatic compliance at least once during the contract term. Monitoring visits may include, but are not limited to:
   a. Review of Participant file documentation;
   b. Review of eligible activity and eligible costs established by HPSP Program guidelines;
   c. Review of policies and procedures and consistent adherence to HPSP Program practices;
   d. HMIS and other data entry completion;
   e. Interviews with program staff
3. County shall monitor the performance of Contractor against the goals, outcomes, and performance standards required herein. Substandard performance, as determined by County, will constitute non-compliance with this Contract for which County may immediately terminate the Contract. If action to correct such substandard performance is not taken by Contractor within the time period specified by County, payment(s) will be denied in accordance with the provisions contained in the Contract.
4. County shall periodically evaluate Contractor's progress in complying with the terms of this Contract. Contractor shall cooperate fully during such monitoring. County shall report the findings of each monitoring to Contractor.

C. Reporting Requirements

1. Contractor is required to submit reporting on monthly and quarterly basis in a form acceptable to County. Monthly reports will be due by the twentieth (20th) day of the following month of services rendered, unless otherwise approved by County. The reporting shall support County in evaluating Contractor's performance as it relates to Participant data, program referrals, linkages and units of services, as outlined below. Contractor/subcontractors will be required to utilize the HMIS to support with data collection, management, and reporting standards and used to collect participant-level data.

2. Contractor is required to submit monthly units of service and narrative reports, in addition to reporting at regular intervals that details the following:
   a. Total number of eligible households that receive assistance;
   b. Eligible participants by Supervisorial District;
   c. Composition of the households – demographics, size and type;
   d. Number of unduplicated participants served, including the total number of households and the total number of individual household members;
   e. Caseload movement;
   f. Financial assistance expenditures;
   g. Length of assistance;
   h. Number of Participants exits and exit types;
   i. Individualized Housing and Service Plan status – total number of plans established with participants.
   j. Permanent housing retention rate;
   k. Income increases for participants;
   l. Other outcome measures as determined by the Administrator and agreed upon by Contractor.

D. File Maintenance and Documentation
   1. Contractor shall prepare all applicable files and perform all administrative management tasks, as indicated in the Contract.
   2. Contractor and subcontractors shall maintain all records required by the federal regulations specified in 24 CFR 570.503(b)(2), 570.506, 570.507, 570.508 that are pertinent to the activities to be funded under this Contract.
   3. Records providing a full description of each activity undertaken.
   4. Financial records as required by 24 CFR 570.502, and OMB Circular A-87; and
   5. Other records necessary to document compliance with Subpart K of 24 CFR 570.
   6. Annual Audit Submission: Independent audits to be performed by a Certified Public Accountant, which shall include an audit of funds received from County, in accordance with applicable regulatory requirements. Copies of each required audit report must be provided to County within thirty (30) calendar days after the date received by Contractor.

7. Retention: Contractor shall retain all records pertinent to expenditures incurred under this Contract for a period of five (5) years after the termination of all activities funded under this Contract, or after the resolution of all federal audit finding, whichever occurs later. Records for non-expendable property acquired with funds under this Contract shall be retained for five (5) years after final disposition of such property. Records for any displaced person must be kept for five (5) years after s/he has received final payment.

VI. STAFFING

A. All personnel assigned to the performance of the services will be closely evaluated by County. Staffing should reflect diverse populations served and demonstrate capacity to function as the provider for the HPSP Program. Staffing should at a minimum include English and Spanish speaking personnel. Staff should demonstrate the ability to communicate effectively in both written and verbal formats, and the ability to problem solve effectively within the structure of the program, the contract, and budgetary parameters, as appropriate to their respective job descriptions.

Contract Period 1: August 12, 2024 – August 11, 2025

ADMINISTRATIVE FTEs	**FY 24-25 FTEs**	**FY 24-25 Leveraged Funds FTEs**
TOTAL ADMINISTRATIVE FTEs	**0.00**	**0.00**
PROGRAM FTEs		
HPSP Program Manager	0.25	0.25
211OC Info & Referral Specialist	0.50	0.50
TOTAL PROGRAM FTEs	**0.75**	**0.75**
Subcontractor FTEs:		
Abrazar – Case Manager	1.00	0.20
Families Forward-Case Manager	1.00	0.20
Mercy House – Case Manager	1.00	0.20
Pathways of Hope – Case Manager	1.00	0.20
South County Outreach – Case Manager	0.50	0.10
TOTAL PROGRAM SUBCONTRACTOR FTEs	**4.50**	**0.90**
TOTAL FTEs	**5.25**	**1.65**

Contract Period 2: August 12, 2025 – August 11, 2026

ADMINISTRATIVE FTEs	**FY 25-26 FTEs**	**FY 25-26 Leveraged Funds FTEs**

TOTAL ADMINISTRATIVE FTEs	**0.00**	**0.00**
PROGRAM FTEs		
HPSP Program Manager	0.25	0.25
211OC Info & Referral Specialist	0.50	0.50
TOTAL PROGRAM FTEs	**0.75**	**0.75**
Subcontractor FTEs:		
Abrazar – Case Manager	1.00	0.20
Families Forward-Case Manager	1.00	0.20
Mercy House – Case Manager	1.00	0.20
Pathways of Hope – Case Manager	1.00	0.20
South County Outreach – Case Manager	0.50	0.10
TOTAL PROGRAM SUBCONTRACTOR FTEs	**4.50**	**0.90**
TOTAL FTEs	**5.25**	**1.65**

1. Staff overseeing direct service shall have an extensive knowledge of the County's System of Care and Homeless Service System and/or at minimum have a bachelor's degree in social work or related field.
2. Staff providing direct services shall consist of at least 50 percent of staff with previous eviction diversion and/or direct human services experience. Human service experience includes but is not limited to providing services that help people find stability and self-sufficiency through case management, addressing basic needs, housing navigation, counseling, etc.
3. If Contractor is proposing three (3) or more direct service staff at least one (1) must be bi-lingual in Spanish. It is preferred to also have direct service staff that is bi-lingual in Vietnamese or any language that is prominently spoken in the area being serviced, in addition to Spanish.
4. Administrative staff shall be assigned to work with the contract and have experience with overseeing and supporting past government contracts.
5. Staffing shall ensure access to service referrals is available during regular business hours while allowing flexibility to operate extended hours on evenings and weekends to accommodate participant needs as determined on a case-by-case basis.

B. Contractor shall provide effective administrative management of the budget, staffing, recording, and reporting portion of the Contract with County. If administrative responsibilities are delegated to subcontractors, Contractor must ensure that any

subcontractor(s) possess the qualifications and capacity to perform all delegated responsibilities. Responsibilities include but are not limited to the following:

1. Designate the responsible position(s) in your organization for managing the funds allocated to this program;
2. Maximize the use of the allocated funds;
3. Ensure timely and accurate reporting;
4. Maintain appropriate staffing levels;
5. Ensure staff possess the qualification and capacity to perform responsibilities tied to the staff's position;
6. Effectively communicate and monitor the program for its success;
7. Maintain communication between the Contract key staff and Program Administrators; and,
8. Act quickly to identify and solve problems.

C. Contractor shall, at a minimum, provide the following staffing pattern expressed in Full-Time Equivalents (FTEs) continuously throughout the term of the Contract. One (1) FTE shall be equal to an average of forty (40) hours work per week.

EXHIBIT A - MA-017-24011491

Commission to End Homelessness

Homeless Service System Pillars Attestation

Please select which of the Homeless Service System Pillar(s) that applies to the services being proposed. **For this RFP, the Prevention Pillar will apply:**

- [X] **PREVENTION**
- [ ] **OUTREACH & SUPPORTIVE SERVICES**
- [ ] **SHELTER**
- [ ] **HOUSING**

Please provide a brief description to outline how your proposal meets the best practices and guiding principles of the selected Homeless Service System Pillar(s). If additional space is needed, please attach separate pages to this Exhibit C.

Orange County United Way's proposal meets the best practices and guiding principles of the Prevention Homeless Service System Pillar, as outlined in the Homeless Service System Pillars Report. This program seeks to prevent homelessness through direct financial assistance and robust case management, coordinating with service providers located in each of the five Orange County Supervisorial Districts to maximize access to services.

We have built early intervention and targeting those "at-risk" into the program, delivering homeless prevention services to individuals and families who most urgently need intervention before losing housing, and also including SparkPoint OC financial coaching to ensure long term stability. By meeting "at risk" families where they are, this one-on-one support through budgeting, building credit, and creating savings helps families become financially prepared to avoid future crises. This will be incorporated into the biweekly case management that is part of this proposal.

We also provide emergency rental assistance and limited financial assistance, according to the prevention pillar. This program will utilize our Whatever it Takes portal, through which eligible households are provided direct financial assistance (through payments to third parties) for rental arrears, past due utility bills, and/or other unexpected financial expenses to address the factors causing the individual or family to experience housing instability and/or imminent risk of homelessness. This funding allows us to remain responsive to the varied needs of those at risk of homelessness.

We also prioritize connections to mainstream benefits and community services through our Key Service, 211OC. By using a closed-loop referral system, GetHelpOC, our clients will have access to other social services that connect them to the community and promote stability, such

as housing, food, transportation, physical health, mental health, child well-being, and more. Information and Referral specialists assess for appropriate public benefits and help participants connect to those services. Case managers will follow up with clients as they go through their appointments and coaching to support clients through this process of prevention.

The overarching goal of this program is to first address Orange County residents' immediate housing crisis, and then help them access the tools to establish long-term housing sustainability. Through robust case management and connection to strategic supportive services, we will assist program participants to build a foundation to promote housing stability and prevent a return to homelessness.

1. Proposer recognizes the Commission to End Homelessness as an advisory body to the Orange County Board of Supervisors, was created to advise on policy and direction related to addressing homelessness in Orange County.

   Initial SBP

2. Proposer acknowledges that the Commission to End Homelessness created the Homeless Service System Pillars Report with the assistance of local and national industry experts and people with lived experience to establish a collective understanding of the interventions, programming and outcomes expected for each pillar. Additionally, the Homeless Service System Pillars Report also identifies the best practices, principles, and commitments to be followed by each Pillar.

   Initial SBP

3. Proposer acknowledges that the Homeless Service System Pillar Report was received and filed by the Orange County Board of Supervisors during the October 16, 2022, meeting. The Orange County Board of Supervisors directed the use of the Homeless Service System Pillars Report be utilized as a framework in the design and development of programs that address the needs of individuals and families at risk of homelessness or experiencing homelessness across the County of Orange.

   Initial SBP

4. Proposer recognizes that through the solicitation process for the proposed project, services must clearly demonstrate and meet the definition, goal, best practices, and guiding principles of the above checked Homeless Service System Pillar(s), based on the Commission to End Homelessness' Homeless Service System Pillars Report.

   Initial SBP

5. Proposer attests the proposal submitted meets the standards of identified best practices and guiding principles defined in the Commission to End Homelessness' Homeless Service System Pillar Report. Proposer also acknowledges that they may be asked to report and/or demonstrate their adherence to the above stated at any point during the duration of the Contract.

SBP — 4/8/24

(Signature Required) **(Date)**

Homeless Prevention and Stabilization Program Outcomes

Scope of Work

We propose to evaluate the effectiveness of the Homeless Prevention and Stabilization Program (HPSP) using a combination of administrative data and data from surveys that will be administered by faculty at the University of California, Irvine. Data will be collected for both the program participants (treatment group) and a sample of similar individuals not enrolled into the program (comparison group).

HPSP aims to assist approximately 200 families and will be rolled out over a two-year period. The program will enroll approximately 100 families (cohort 1 & cohort 2) in each year. Based on eligibility criteria, most of the families included in the treatment and comparison group (total 600) will be Medi-Cal eligible. Based on the outcomes listed below, CalOptima and its clients will benefit by knowing how HPSP impacts self-reported wellbeing and health services utilization.

Surveys will be administered at the following points in time for each cohort:

- Intake survey (see Recruitment Strategy below on the process to identify HPSP participants and the comparison group; This applies to cohort 2 only as the first cohort surveys were covered by the initial contract.)
- Six-month follow-up survey (Cohort 1 and 2)
- 18-month follow up survey (Cohort 1 and 2).

In consultation with our partners in Supervisor Vincente Sarmiento office as well as the service provider (OC United Way and OC 211), the survey (attached) was designed to capture the following outcomes:

Housing Stability

We will collect information on housing circumstances and housing instability among the treatment and comparison groups from a combination of survey and administrative data. The baseline and follow-up surveys will ask about housing conditions as well as housing security and stability, including threats of evictions and what measures were taken to avoid eviction. The survey will also capture changes in one's place of residence. Frequent moves are endemic among individuals trying to avoid eviction. However, funds provided by the HPSP might help to avoid moves, or in some cases possibly facilitate moves to better quality housing.

These survey outcomes will be complemented by administrative data (Court Records) measuring the rate of eviction. We can examine the likelihood of an eviction filing for

individuals in periods after study enrollment. We can also measure eviction filings prior to study enrollment in order to assess sample similarity among those who do and do not receive HPSP assistance. We will match individuals who consent to participation in the study to court records based on name and other information provided at baseline. Funds provided by the HPSP may help individuals avoid eviction filings, thereby increasing housing security.

Using both survey and administrative data to measure outcomes of interest is important because they each have strengths and limitations. Surveys allow participants to report a range of comprehensive experiences and perceptions about housing stability, but they depend on participants successfully completing those surveys and their willingness (and capacity) to accurately report experiences (both of which could be influenced themselves by housing instability). Administrative data can be collected for all consenting participants, enabling more comprehensive coverage of participants, even if the outcome is limited to eviction.

Financial Stability/Employment

Survey questions will be asked about employment status, financial security, and participation in educational/vocational training programs. Changes in hours worked, wages and transitioning to higher paying employment sectors will be analyzed. In addition to changes in debt related to housing costs/rent, outstanding medical, car, and other consumer debt will be measured. Changes in banking practices including use of high-fee lending/check cashing services will be measured.

Health and Well-being

This study will gather essential information about the health and well-being of participants, providing a comprehensive understanding of how homelessness prevention efforts impact lives. We'll use self-reported measures of well-being along with data on health care utilization to create a complete picture of participants' experiences.

The initial survey will focus on health care usage over the past 12-months, establishing a vital baseline. By looking at metrics such as Emergency Room Visits, Hospitalizations, and visits with one's Primary Care Physician, as well as the barriers to accessing care, we can identify trends in how individuals who have faced housing instability use health services. This information will be crucial for showing how effective our interventions are in improving access to care and reducing dependence on emergency services.

The insights from this survey will empower us to advocate for targeted health interventions and inform policy decisions that can lead to meaningful change. By highlighting the link between stable housing and better health outcomes, we aim to foster a healthier and more resilient community.

We will collect information on health and well-being. Self-reported measures of well-being and utilization of health care services will be collected from surveys. The initial survey will ask individuals to recall health care utilization for the prior 12 months. This will provide a baseline measure to identify changes is the usage of such services as Emergency Room Visits, Hospitalization, and pharmacy visits. The survey will ask individuals about their experiences with psychological distress, anxiety, and depression.

Utilization of Program Funds (Treatment Group Only)

Data permitting, we will collect both survey and administrative information on use of the cash assistance provided under the program. The surveys conducted following program enrollment will include a series of questions applicable to only individuals in the treatment group. These questions will ask about how monthly cash transferred were used (food, rent, transportation, paying down debt, etc.). Additional questions will provide insight on whether the value of the lump sum outweighed the value of monthly payments, and participant's overall experience with the program. Depending on how the cash assistance is delivered (e.g., if it is deposited on a debit card) and cognizant of privacy issues, we may also be able to track the broad temporal patterns and/or broad categories of spending by those who receive HPSP assistance.

Participation in the Evaluation:

HPSP varies in eligibility and program benefits across districts. Districts 2 and 3, unlike the other districts, are consistent across eligibility and benefits. The evaluation will focus on the effectiveness of the HPSP program as defined in Districts 2 and 3, which combined will enroll close to two-thirds of HPSP participants. The research team will collect information on the families participating in other Districts 1, 4, and 5; however, for statistical power reasons, the evaluation is focused on those families participating in HPSP in Districts 2 and 3 as compared to similar families (comparison group). Any analysis of participants in Districts 1, 4, and 5 will be only suggestive; we will not be able to draw any definitive conclusions as to whether the rental assistance provided in those districts had meaningful effects.

Recruitment Strategy:

Our recruitment strategy incorporates best practices and suggestions from the literature addressing trauma-informed recruitment, as well as standard ethical practices. We are proposing to recruit participants at the point of screening by the selected service provider,

Orange County 2-1-1 (OC 211). In particular, we will recruit survey participants (including both HPSP and comparison group participants) during the 211 screening process, while HPSP remains "open" for participation.

For those callers who are initially deemed eligible for HPSP, 211 will ask callers if they are willing to be contacted by the UC Irvine team for information about participating in an online survey study about housing in Orange County. We have created a short script for the 211 screener to read to the callers. The script is very clear that willingness to learn more about the research study has no impact on HPSP program eligibility or any other services received.

OC 211 will provide UCI the names/contact information for all individuals that agreed to be contacted by the research team. Using the preferred method indicated (e.g., telephone, email, text) the research team will contact callers with the survey information and link for completing the survey. We expect most families will prefer to fill out the online survey on their own time without assistance, but providing this assistance will give more support to those that desire it.

The survey itself takes approximately 30 minutes to complete. Once the responses are submitted and verified, families will be compensated a $40 gift card of their choice for their time and participation.

We are seeking a control group (those who meet eligibility requirements but, because of constraints on the size of the program, cannot participate) that is twice the size of the treatment group (those who do participate). Because each district has a specific number of slots in HPSP and eligibility requirements vary slightly across districts, we will stratify by district. That is, within each district, we aim to have 2 control participants for every 1 treatment participant. Based on conversations with 211 and other study partners, we anticipate there will be far more families calling in who will meet eligibility requirements for the program than there will be slots for actual program participation (which will be first-come, first-serve).

Project Milestones/Time Line:

Timeline	**Deliverable**
January 1, 2025	Continue to collect baseline survey responses for Cohort 1 and populate secure database with responses
April - May 2025	Administer 6-month survey for Cohort 1
October 2025	Administer baseline survey for Cohort 2
April - May 2026	Administer 6-month survey for Cohort 2 Administer 18-month survey for Cohort 1

Timeline	**Deliverable**
April - May 2027	Administer 18-month survey for Cohort 2
June 30, 2027	Submit final report

Budget Narrative for UCI Evaluation Budget

Total Budget: $269,703

Time Period: January 1, 2025 - June 30, 2027

Purpose: This budget is dedicated to a comprehensive evaluation study of the Homelessness Prevention and Stabilization Program (HPSP) as outlined in the Statement of Work. This involves the implementation of five surveys conducted over two years and careful analyses of the survey and other administrative data. The proposed evaluation is critical to understanding the impact of HPSP suggest ways in which service delivery and program outcomes might be improved.

Budget Breakdown:

- **Total Staffing Costs: $243,139**
  - **Faculty Staffing ($86,176)**
    - Lead the evaluation design and oversee the research process, ensuring rigorous methodology and alignment with study goals.
    - Attend weekly meetings with OC 211 staff to monitor progress of program enrollment and answer any questions that arise.
    - Responsible for overseeing the implementation of surveys, engaging with participants, and collecting data. Their role includes:
      - Designing and administering surveys.
      - Analyzing survey results to extract meaningful insights.
      - Supporting the overall evaluation framework.
    - Write draft, meet with stakeholders to discuss preliminary findings, incorporate feedback and produce final reports and presentations.
  - **Graduate Student Support ($150,963)**
    - Will assist on all phases of the evaluation.
    - Responsible for sending the survey link to participants, monitoring for completion, sending reminders as necessary, and once complete, sending the electronic gift card.
    - Includes tuition, fees, and monthly salary.
- **Other Expenses: $6,000**
  - Cover necessary travel for survey administration and stakeholder collaboration, including the presentation of results.
  - Translation services for making survey instrument and all documents accessible to participants in participant's native language.

Total Direct Costs: $243,139

Facilities and Administrative Costs: $26,564

- These costs support the management and oversight of the project and cover the University's expenses for rent, administrative support, office space, and nominal supplies.

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
20. Approve Actions Related to the Street Medicine Program Expansion

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, (714) 954-2140

Recommended Actions
1. Approve a notice of interest opportunity to identify one additional host-city for the expansion of CalOptima Health's Street Medicine Program.

Background
On March 17, 2022, CalOptima Health's Board of Directors (Board) committed $8 million from the Homeless Health Initiatives Reserve for purposes of street medicine. On May 5, 2022, the Board approved the Street Medicine Program scope of work (SOW). On November 3, 2022, the Board authorized the Chief Executive Officer to execute a contract with Healthcare in Action to provide street medicine canvasing-based services. The pilot launched in Garden Grove on April 1, 2023. In accordance with CalOptima Health's strategic priority of overcoming health disparities, and based on the success of the program in Garden Grove, on October 5, 2023, the Board unanimously voted to:

1. Authorize CalOptima Health staff to expand CalOptima Health's Street Medicine Program into two additional cities;
2. Approve the notice of interest opportunity process that would be released to cities, including commitments from CalOptima Health as well as evaluation criteria based on a series of questions; and
3. Approve the scope of work for the request of qualifications (RFQu) to identify providers capable of implementing the Street Medicine Program.

CalOptima Health launched the RFQu for street medicine providers on November 9, 2023. On December 7, 2023, the Board authorized CalOptima Health to expand its Street Medicine Program to the cities of Anaheim and Costa Mesa. On March 7, 2024, the Board approved Celebrating Life Community Health Center to provides street medicine services in Costa Mesa and Healthcare in Action to provide street medicine services in Anaheim. The programs launched on August 12, 2024, and September 3, 2024, respectively.

Discussion
Street medicine includes health and social services developed specifically to address the unique needs and circumstances of unsheltered individuals. The fundamental approach of street medicine is to engage people experiencing homelessness where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through services. Working in collaboration with various

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county, city, and community organizations, street medicine's ultimate goal is to address and improve the overall health outcomes of the unsheltered, unhoused individuals served.

Since the April 1, 2023, launch of CalOptima Health's Street Medicine Program, over 475 individuals experiencing homelessness have been enrolled and 100% of them are receiving primary medical care, including, but not limited to, ongoing medical care, ordering and reading labs, prescribed medications, referrals to specialists as needed and urgent care. In addition, 97% have voluntarily enrolled in California Advancing and Innovating Medi-Cal (CalAIM) Enhanced Care Management and/or Community Support Services.

Given the success of CalOptima Health's Street Medicine Program, staff is requesting the Board's approval to expand the Street Medicine Program to one additional city. To select an additional city in an equitable and transparent manner, CalOptima Health staff is requesting the Board approve a notice of interest opportunity. The notice of interest opportunity includes a series of attestations and questions, as well as requirement that a letter of support signed by the City Manager be uploaded into the application portal. *See* Attachment 1. With the Board's approval, the notice of interest opportunity will be launched no sooner than December 6, 2024, and close in January 2025. At that time, a committee of evaluators from CalOptima Health will review and score the submissions. CalOptima Health staff will return to the Board at the March 2025 meeting to request approval of the selected city.

Fiscal Impact
The recommended action has no immediate fiscal impact. Staff will return to the Board to request a funding allocation to align with the result of the notice of interest opportunity at a future meeting.

Rationale for Recommendation
In order to engage CalOptima Health members experiencing homelessness where they are and on their own terms, to reduce or eliminate barriers to medical and social care, and with the success of CalOptima Health's Street Medicine Program operating in Anaheim, Costa Mesa, and Garden Grove, CalOptima Health staff would like to expand the Street Medicine Program to one additional city in 2025.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Health Notice of Interest Opportunity

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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CalOptima Health:
Notice of Interest Opportunity for Street Medicine Expansion

CalOptima Health is accepting letters of interest from individual Orange County cities to expand its Street Medicine Program.

Application Deadline – January 17, 2025, 5 p.m. (PST)

Background

CalOptima Health's mission is to serve member health with excellence and dignity, respecting the value and needs of each person. In line with that mission, CalOptima Health has made a commitment to address the health of our unsheltered members through our partnership-driven Street Medicine Program. Street medicine includes health and social services specifically developed to meet the unique needs and circumstances of unsheltered individuals. The fundamental approach of street medicine is to engage people experiencing homelessness where they are and on their own terms in order to maximally reduce or eliminate barriers to care and follow-through services. Working in collaboration with various county, city and community organizations, CalOptima Health's Street Medicine Program's ultimate goal is to improve the overall health and housing status of the unsheltered individuals served.

CalOptima Health's Street Medicine Program Values and Philosophies

CalOptima Health's Street Medicine Program is a critical piece of a larger, comprehensive approach to caring for our members living on the street and on their journey home. In addition to being able to provide important preventive services, urgent care and social services, this program fosters the relationship building that is key to helping a person into a permanent home. CalOptima Health's Street Medicine Program relies on three integrated components to achieve those health and housing outcomes: (1) outreach and engagement, (2) coordinated medical care that meets people where they are, and (3) comprehensive Enhanced Care Management (ECM) and Community Supports.

The Street Medicine Program has a set of core values and philosophies that are recognized as best practices and, as research has demonstrated, drives the program toward success. First is the practice of

trauma-informed care, which includes the principles of safety, choice, collaboration, trustworthiness and empowerment. In practice, this entails meeting individuals where they are both literally and figuratively. Street medicine providers meet individuals in their identified home while showing the individual unconditional positive regard. The Street Medicine Program follows the philosophy of rapport first and care second, meaning the relationship the provider develops with those they serve is the foremost priority. Only once rapport is established can there be meaningful physical care. Similarly, the person must come first in street medicine, and being person-centered is a core philosophy of the program.

In addition to the above, utilizing a canvassing approach is crucial to street medicine. It goes hand in hand with meeting members where they are and takes some of the work, coordination and stress off the individual, as they do not have to navigate to a brick-and-mortar location. The street medicine providers canvas an identified geographical location to both enroll new individuals and provide comprehensive medical and social care, including ECM and Community Supports.

By ensuring the above philosophies and values are at the heart of the CalOptima Health Street Medicine Program, we are confident all selected street medicine providers can effectively treat the whole person and move them towards achieving the goals of the program.

Description of CalOptima Health's Street Medicine Program

The foundation of CalOptima Health's Street Medicine Program is two collaborative care teams, a coordination care team and a medical care team, that provide integrated outreach, engagement and comprehensive service provision. Collectively these teams engage in a canvassing-based approach to identify unsheltered members in the field and connect them to necessary preventive, urgent and primary care services. The coordination care team members are primarily responsible for identifying eligible members who agree to participate in the program and then providing services such as ECM, housing navigation (and additional housing-related Community Supports as applicable), routine face-to-face visits to address various medical needs and scheduling appointments with the medical care team. The medical care team is responsible for primary medical care including, but not limited to, ongoing medical care, ordering and reading labs, prescribing medications, and referrals to specialists and urgent care as needed. The medical care team offers all enrolled patients the opportunity to have the street medicine providers serve as their primary care provider (PCP). Together, these teams are designed to serve a caseload of up to 200 unsheltered members.

To ensure proper care and support for patients enrolled in the program, service provision standards have been established. For the medical care team, there is to be a minimum of one patient encounter with every person enrolled in the program every 60 days, with encounters varying depending on the acuity of medical needs. For the coordination care team, there is to be a minimum of one patient encounter with every person enrolled in the program per week. Services are more frequently provided based on each patient's specific needs.

CalOptima Health's Commitment

While CalOptima Health serves as the lead of our Street Medicine Program, we believe that a partnership-driven, collaborative effort between CalOptima Health and city personnel leads to the most effective and sustainable outcomes for our members living on the street.

In support of this partnership, CalOptima Health is committed to:

1. Delivering compassionate and dignified medical and social care to its unsheltered members to reduce barriers to quality medical and social care and improve the health outcomes of unsheltered individuals.
2. Collaborating with the selected city to ensure seamless integration of its Street Medicine Program with consideration of the city's broader endeavors to address homelessness.
3. Proactively engaging with the selected city in the planning process and maintaining transparent communication throughout.
4. Inviting the selected city to provide feedback on the top two provider proposals for their city.
5. Financially supporting the startup and launch of a street medicine team designed to serve a caseload of 200 unsheltered members.
6. Scheduling and chairing regular Steering Committee meetings and inviting all relevant stakeholders.
7. Closely supervising the providers to ensure the effective realization of the program's goals and objectives.
8. Providing routine outcome data to the city based on the goals of CalOptima Health's Street Medicine Program.
9. Allocating space for the street medicine providers and the van on CalOptima Health property.
10. Remaining receptive to feedback from the city pertaining to its Street Medicine Program.

City's Commitment

In support of this partnership, the selected city commits to:

1. Collaborating with CalOptima Health to welcome street medicine services within the city's jurisdiction, thereby supporting the compassionate and dignified treatment of its unsheltered residents in order to foster a sense of belonging within the community and improve their health outcomes.
2. Attesting their 2024 Point-in-Time Count showed a minimum of 200 unsheltered individuals OR, alternatively, providing data proving such.
3. Formally recognizing CalOptima Health as the program lead and acting in support of CalOptima Health's Street Medicine Program framework.
4. Directing all questions related to the Program to CalOptima Health staff, not its contracted Provider.
5. Providing feedback in selecting a street medicine provider.
6. Collaborating with the provider CalOptima Health selects for service provision.

7. Allowing CalOptima's Provider to refer directly into any city shelter(s) and/or housing program, if applicable.
8. Sharing data on unhoused city residents with CalOptima Health, as appropriate or needed.
9. Actively participating in the planning and implementation of the Street Medicine Program by attending the Street Medicine Steering Committee meetings.
10. Ensuring that law enforcement and fire personnel actively engage in the collaborative efforts needed to effectively run the Street Medicine Program.
11. Allowing CalOptima Health's Street Medicine Program to serve all zip codes within the city's jurisdiction.
12. Assisting in locating properties within the city's jurisdiction that can serve as street medicine support centers in Phase II of CalOptima Health's Street Medicine Program.
13. Supporting the Street Medicine Program launch in their city no sooner than October 2025.

Evaluation Criteria

	Criterion	Maximum Points	Basis for Assigning Points
1.	CalOptima Health core value alignment, including commitment to treat individuals with dignity and respect	20	City's demonstrated commitment to trauma-informed, inclusive, person-centered programs and those that align with harm-reduction principles.
2.	Comprehensive, existing efforts and strategies to address homelessness	15	City must demonstrate experience and commitment to addressing the homelessness crisis.
3.	Existing partnerships and community involvement	15	City must describe existing partnerships that will positively contribute to the Street Medicine Program.
4.	Uploaded letter of interest	5	Application portal includes a letter of interest that must be signed by the city manager.
5.	All attestations complete	5	Application portal includes attestations that must be made regarding the Street Medicine Program.
Total Earnable Points		**60**	

Timeline

Activity	Date
Portal opens	Dec. 6, 2024, at 9 a.m.
Application deadline	Jan. 17, 2025, at 5 p.m.
Internal review	Jan. 20 – Feb. 14, 2025
CalOptima Health Board of Directors Meeting	Mar. 6, 2025

Documents and Portal Access

The letter of interest template, a series of qualitative questions, as well as the required city attestations will be made available on the following portal:

[insert weblink]

Questions about this opportunity? Contact Nicole Garcia, Director, Medi-Cal and CalAIM, at nicole.garcia@caloptima.org.

Notice of Interest Opportunity Application

Questions for the City

1. Does your city have a comprehensive, person-centered strategy to address homelessness, and, if so, how are you implementing it?
2. What service and housing options are available for unsheltered individuals in your city?
3. Does your city have any shelters? If so, who operates them and how many beds?
4. How does your city collaborate with other municipalities, the County of Orange, local shelters, nonprofits or other non-governmental organizations to support the unsheltered population?
5. What role do law enforcement and fire personnel play in addressing homelessness in your city?
6. Does your city have specific ordinances related to the unsheltered that could impact CalOptima Health's Street Medicine Program?

Attestations:

1. The city attests to its commitment to collaborate with CalOptima Health to welcome street medicine services within the city's jurisdiction, thereby supporting the compassionate and dignified treatment of its unsheltered residents in order to foster a sense of belonging within the community and improve their health outcomes.
2. The city attests to having a minimum of 200 unsheltered homeless people during the 2024 Point-in-Time Count. Alternatively, the city attests that it possesses verifiable data demonstrating the presence of a minimum of 200 unsheltered homeless individuals currently residing within its jurisdiction.
3. The city attests to formally recognizing CalOptima Health as the program lead and acting in support of CalOptima Health's Street Medicine Program framework.
4. The city attests to directing all questions related to CalOptima's Street Medicine Program to CalOptima Health staff, not its contracted Provider.
5. The city attests to its commitment to provide feedback in the process of selecting a street medicine provider.
6. The city attests to its willingness to collaborate with the provider selected by CalOptima Health for the provision of street medicine services.
7. The city attests to allowing CalOptima's Provider to refer directly into any city shelter(s) and/or housing program(s), if applicable.
8. The city attests to its willingness to share appropriate or needed data regarding unhoused residents with CalOptima Health.
9. The city attests to its active participation in the planning and implementation of CalOptima Health's Street Medicine Program, including attendance at Street Medicine Steering Committee meetings.

10. The city attests to ensuring active engagement of law enforcement and fire personnel in the collaborative efforts necessary for the effective operation of CalOptima Health's Street Medicine Program.
11. The city attests to granting permission to CalOptima Health's Street Medicine Program to serve all zip codes falling within the city's jurisdiction.
12. The city attests to its commitment to assist in identifying suitable properties that can function as a street medicine support center in Phase II of CalOptima Health's Street Medicine Program.
13. The city attests to the agreement that CalOptima Health's Street Medicine Program will commence no earlier than October 2025 within its jurisdiction.

Letter Upload on City Letterhead and Signed by the City Manager

Date

Michael Hunn
Chief Executive Officer
CalOptima Health
505 City Parkway West
Orange, CA 92868

Subject: Letter of Interest — CalOptima Health Street Medicine Program

Dear Mr. Hunn,

I am writing on behalf of [City Name] to express our keen interest in collaborating with CalOptima Health as a host city for the expansion of CalOptima Health's Street Medicine Program in 2025.

We have reviewed and agreed to the attestations within the online platform for CalOptima Health's Street Medicine opportunity and this letter reflects our commitment to be a collaborative partner if our city were to be selected.

We recognize the importance of integrating our resources and expertise with your existing Street Medicine Program and our city is committed to addressing the health care needs of its unsheltered neighbors.

Sincerely,

[Name]
[City Manager]

Cc:

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

21. Approve Actions Related to the Housing and Homelessness Incentive Program

Contacts

Kelly Bruno Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1. Approve allocation of up to $19.73 million in Housing and Homelessness Incentive Program (HHIP) funds earned through the Submission 2 report from the California Department of Health Care Services pursuant to Attachment 1: HHIP Allocation and Awards.
2. Authorize CalOptima Health staff to develop notices of funding opportunities (NOFO) pursuant to Attachment 2: Anticipated NOFO Rounds 4, 5 and 6, totaling $20.13 million, including the $400,000 balance from the HHIP NOFO Round 3 for Equity grants under Priority Area 2.
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background

CalOptima Health began participating in the California Department of Health Care Services (DHCS) 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 and contracts, are designed to improve the services and care for CalOptima Health 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 $72.93 million, or 87% of eligible incentive dollars. In addition, the CalOptima Health Board of Directors (Board) approved 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 $25.0 million in December 2023, as presented in the Board action table below. The DHCS HHIP incentive dollars earned plus Board allocated reserves dollars total $160.3 million.

CalOptima Health has stewarded these funds into significant community investment over the past two years, awarding $116.58 million of those total funds across four priority areas (as listed in the table below). There remains $6 million in funds committed to priority areas but not yet spent, and $37.73 million in funding not allocated to any priority.

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Board-approved Priority Area	Board Allocated	Amount Awarded	Allocated but Not Awarded
Priority 1. Delivery of services and member engagement	$3.6	$3.0	$0.6
Priority 2. Infrastructure to coordinate and meet member housing needs	$9.8	$9.4	$0.4
Priority 3. Partnerships and capacity to support referrals (capital)	$98.3	$93.3	$5
Priority 4. Innovation and implementation of strategic interventions (systems change)	$10.88	$10.88	
TOTAL ALLOCATED TO A PRIORITY	$122.58	$116.58	$6.0

*in millions

Attachment 3 includes a list of all grants made within the above priority areas, totaling $116.58 million.

Discussion

After two years of substantial community investment, CalOptima Health wanted to take stock of the collective impact of these funds and clarify the funding priorities for future investments. A report of HHIP progress to-date can be found in Attachment 4. To solicit community feedback, CalOptima Health planned and hosted a series of five community listening sessions in late summer and early fall of 2024. The listening sessions generated many perspectives and input, reinforcing the overall four funding priorities, but also providing recommendations for specific investments within those priorities. Based on that feedback, CalOptima Health staff proposes to allocate $19.73 million of the $37.73 million remaining in unallocated HHIP funding in the following manner.

Priority 2: Infrastructure to coordinate and meet member housing needs (Capacity Building and Equity Grants)

Allocate $600,000 to Priority 2 to continue supporting small, grassroot organizations reaching equity populations throughout Orange County with housing-related services. These grants have helped to support a variety of community-based organizations in their capacity building efforts to expand their outreach and engagement of special populations. Per the second Board action presented above, staff will also include the remaining $400,000 from the HHIP NOFO Round 3 Equity Priority toward the NOFO Round 4 Equity Priority. CalOptima Health staff will distribute the cumulative of $1 million across two NOFOs over the next 24 months.

Priority 3: Partnerships and capacity to support referrals for services (Capital Projects)

Allocate $10 million to Priority 3, which will support enhancements or expansions on affordable or permanent supportive housing, specifically for special populations such as LGBTQIA+, older adults, or individuals with disabilities.

Priority 4: Innovation and implementation of strategic interventions (Systems Change Projects)

Allocate a total of $9.13 million to Priority 4 to continue funding systems change programs, with a focus on prevention programs.

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Board-approved Priority Area	Recommended HHIP Funding Allocation
Priority 2: Infrastructure to Coordinate and Meet Member Housing Needs	$0.6 million
Priority 3: Partnerships and Capacity to Support Referrals for Services	$10.0 million
Priority 4: Innovation and Implementation of Strategic Interventions	$9.13 million
TOTAL ALLOCATION	**$19.73 million**
Unspent amount from previous NOFOs for Priority 2	$0.4 million
Total for Upcoming NOFOs	**$20.13 million**

Of the dollars allocated above, CalOptima Health staff are seeking to award these dollars through competitive notices of funding opportunities over the next two years (summarized in Attachment 2). The total available to award will be $20.13 million. These dollars will be awarded through the following opportunities:

Notice of Funding Opportunity Round 4 (Quarter 1 2025): $5.5 million
CalOptima Health staff will solicit proposals for (i) $500,000 total in equity grants for organizations working in the housing and homelessness sector to serve populations at greater risk for health inequities under Priority 2, and (ii) $5 million total in systems change grants that are specifically focused on innovative prevention projects under Priority 4.

Notice of Funding Opportunity Round 5 (Quarter 3 2025): $10 million
CalOptima Health staff will solicit proposals for $10 million total in capital projects for Priority 3 specifically focused on enhancements or expansions on affordable or permanent supportive housing, specifically for special populations such as LGBTQIA+, older adults, or individuals with disabilities.

Notice of Funding Opportunity Round 6 (Quarter 1 2026): $4.63 million
CalOptima Health staff will solicit proposals for (i) $500,000 total in equity grants for small, grassroots organizations working in the housing and homelessness sector under Priority 2, and (ii) $4.13 million total in systems change grants that impact the housing and homelessness services sector under Priority 4.

Upcoming NOFO To Award Allocated Funds	Total Funds Available to Be Awarded During the NOFO Process
NOFO Round 4	$5.5 million
NOFO Round 5	$10 million
NOFO Round 6	$4.63 million
Total allocated	$20.13 million

Upon Board approval of this action, there will be $18.0 million remaining in unallocated HHIP funds, and previously Board allocated but unawarded amounts of $0.6 million to Priority 1, and $5.0 million to Priority 3. Staff will return to the Board at a future meeting with additional recommendations. Not allocating the full amount at this time will enable staff to monitor the demand for funds in each of these priorities and ensure future funding opportunities continue to reflect the needs of the community.

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Fiscal Impact

The allocation of up to $19.73 million in funding from DHCS has no net fiscal impact on the CalOptima Health Fiscal Year 2024-25 Operating Budget. The increased amounts attributable to HHIP 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). CalOptima Health reserves the right to recoup funds for lack of demonstrated effort or for not meeting grant requirements.

Rationale for Recommendation

CalOptima Health has earned significant incentive dollars to be used in conjunction with its efforts to address the crisis of homelessness among its membership. The actions recommended above will guide CalOptima Health in making investments into the community that reflect current need, will leverage existing opportunities, and will build on past investments to continue supporting CalOptima Health's unhoused members and those at-risk of homelessness.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. HHIP New Allocations
2. HHIP Grantees To-Date
3. HHIP Progress Report
4. Upcoming NOFOs

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

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Board Meeting Dates	Action	Term	Not to Exceed Amount
May 2, 2024	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$25 million

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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HHIP Priority Areas and Initiatives	Funding Allocation						Amounts for NOFO/RFP					
	Allocation 1 (BOD 3/2/23)	Allocation 2 (BOD 6/1/23)	Allocation 3 (BOD 12/7/23)	Allocation 4 (BOD 5/2/24 to borrow against future payment)	Allocation 4 (Proposed BOD Action 12/5/24)	Total Allocation	Awards from NOFO Round 1 (BOD 3/2/23) or Contracted	Awards from NOFO Round 2	Awards from NOFO Round 3	Awards from Nonprofit Healthcare Academy	Total Awards	Balance Available For Future NOFOs
Priority 1: Delivery of services and member engagement	3.60					**3.60**	3.00				**3.00**	0.60
Priority 2: Infrastructure to coordinate and meet member housing needs												
Equity Grants for Programs Serving Underrepresented Populations	3.00	1.00			0.60	**4.60**	3.00		0.60		**3.60**	1.00
Infrastructure Projects	5.83					**5.83**	5.83				**5.83**	0.00
Priority 3: Partnerships and capacity to support referrals for services												
Capital Projects	40.25	33.05	25.00		10.00	**108.30**	21.00	52.30	20.00		**93.30**	15.00
						0.00						0.00
Priority 4: Innovation and implementation of strategic interventions												
System Change Projects		10.18			9.13	**19.31**			10.18		**10.18**	9.13
Non-profit Healthcare Academy		0.35		0.35		**0.70**				0.70	**0.70**	0.00
Total	**52.68**	**44.58**	**25.00**	**0.35**	**19.73**	**142.34**	**32.83**	**52.30**	**30.78**	**0.70**	**116.58**	**25.73**
Remains Unallocated to a Priority					18.00	**18.00**						18.00
Will come back to the board at a later date												
Total with unallocated funds					**37.73**	**160.32**					**116.58**	**43.73**

*Totals may not add due to rounding

Board Actions to Allocate Funds:

9/1/22: Initial $40.1 million reallocation from CalOptima Health Homeless Health Initiative reserve
3/2/23: $12.6 million from DHCS HHIP funding (Local Homelessness Plan and Investment Plan submissions)
6/1/23: $22.3 million from DHCS HHIP funding (Submission 1 Report)
6/1/23: $22.3 million from CalOptima Health Reserves allocated to Capital Projects
12/7/23: $25 million from CalOptima Health Reserves allocated to Capital Projects for Transitional Housing
5/2/24: $350,000 from anticipated DHCS Payment 4 allocated to Priority 4 for Nonprofit Healthcare Academy
*Anticipated 12/5/24: $19.73 million from DHCS Payment 4 Allocations

Board Actions to Grant Out Funds:

3/2/23: Approve Round 1 Grantees
10/5/23: Approve Round 2 Grantees: Capital Grants
4/9/24: Approve Round 3 Grantees: Systems Change and Equity Grants
5/2/24: Approve Round 3 Grantees: Transitional Housing Grants

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Exhibit 2: Housing and Homeless Incentive Program: Upcoming Notice of Funding Opportunities

	2025 Q1	2025 Q3	2026 Q1	
Priority Area	**Round 4**	**Round 5**	**Round 6**	**Total**
Priority 2: Equity	$ 500,000	$ -	$ 500,000	$ 1,000,000
Priority 3: Capital: Improvements/Expansions for Special Populations	$-	$ 10,000,000	$ -	$ 10,000,000
Priority 4: Systems Change Projects (Prevention Concepts in Round 4)	$ 5,000,000	$ -	$ 4,130,195	$ 9,130,195
Total	$ 5,500,000	$ 10,000,000	$ 4,630,195	$ 20,130,195

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Attachment to the December 5, 2024 Board of Directors Meeting – Agenda Item 21

Housing and Homelessness Incentive Program (HHIP) Grantees By Priority Area

Priority Area 1	$3.0 million
Priority Area 2	$9.4 million
Priority Area 3	$93.3 million
Priority Area 4	$10.88 million
Total	$116.58 million

Priority Area 1. $3.0 million

Entity	Amount
Orange County Office of Care Coordination (Continuum of Care)	$2,200,000
Pulse For Good (total project budget less the dollars granted out to participating entities below)	$170,000
Access California Services	$30,000
Advanced Healthcare Administration	$30,000
Collette's Children's Home	$30,000
Families Forward	$30,000
Family Assistance Ministries	$30,000
Family Promise OC	$30,000
Friendship Shelter	$30,000
HIS-OC	$30,000
Illumination Foundation	$30,000
Korean Community Services	$30,000
Leading Purpose	$30,000
Lutheran Social Services of Southern California	$30,000
Mercy House	$30,000
Orange County Asian and Pacific Islander Community Alliance	$30,000
PATH	$30,000
Pathways of Hope OC	$30,000
South County Outreach	$30,000
The Hub Resource Center	$30,000
The Salvation Army	$30,000
Thomas House Family Shelter	$30,000
WISEPlace	$30,000
Total	$3,000,000

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Priority Area 2. $9.4 million

Entity	Amount
Access California Services	$498,427
Advance OC	$100,000
AIDS Services Foundation OC, aka Radiant Health Center	$474,490
Alianza Translatinx	$221,600
Asian American Senior Citizens Service Center	$300,000
City of Anaheim	$200,000
Colette's Children's Home	$350,000
Community Action Partnership of Orange	$79,203
Families Forward	$275,128
Family Assistance Ministries (FAM)	$350,000
Family Promises of OC	$300,000
Friendship Shelter	$197,608
Grandma's House of Hope	$80,000
Grandma's House of Hope	$50,000
Homeless Intervention Services of OC	$370,000
Latino Health Access (LHA)	$500,000
Lutheran Social Services of Southern California	$250,000
My Safe Harbor, Inc.	$100,000
OC Family Justice Center Foundation	$82,860
OC United Together, Inc.	$100,000
Orange County United Way	$1,588,215
PATH	$883,637
Pathways of Hope	$280,000
Shelter Providers of Orange County, Inc., DBA HomeAid Orange County	$100,000
South County Outreach	$130,000
Southland Integrated Services	$450,000
StandUp for Kids	$198,024
The Eli Home, Inc.	$175,000
The Kennedy Commission	$100,000
Thomas House Family Shelter	$254,033
Vital Access Care Foundation (VACF)	$100,000
WISEPlace	$315,400
Total	$9,453,625

Priority Area 3. $93.3 million

Entity	Amount
American Family Housing	$2,951,660
Anaheim Housing Authority	$3,878,420
C&C Development	$8,000,000
Casa Youth Shelter	$4,000,000
City of Anaheim - Housing and Community Development Department	$1,500,000
City of Anaheim/Anaheim Housing Authority	$2,000,000
City of Brea	$6,028,492
City of Yorba Linda	$3,100,000
Community Action Partnership of Orange	$98,340
Community Development Partners	$8,000,000
Families Forward	$2,500,000
Friendship Shelter	$3,850,000
Golden State Recuperative Care, Inc.	$3,500,000
Hart Community Homes, Inc.	$4,000,000
Illumination Foundation	$3,000,000
Jamboree Housing Corporation	$4,721,241
Kingdom Causes dba City Net	$1,337,170
Korean Community Services dba KCS Health Center	$2,500,000
Mercy Housing California	$1,500,000
Mind OC/Be Well OC	$5,000,000
National Community Renaissance of California	$1,334,677
Orange County Housing Finance Trust	$4,000,000
Pathways of Hope	$1,500,000
Shelter Providers of Orange County, Inc., DBA HomeAid Orange County	$1,400,000
The Eli Home, Inc	$5,000,000
The Illumination Foundation	$3,500,000
The Salvation Army Orange County	$4,100,000
WISEPlace	$1,000,000
Total	$93,300,000

Priority Area 4. $10.88 million

Entity	Amount
Jamboree Housing Corporation	$3,000,000
Multi-Ethnic Collaborative of Community Agencies (MECCA)	$2,052,073
Orange County Housing Finance Trust	$3,000,000
Project Hope Alliance	$2,127,927
Nonprofit Healthcare Academy Program Contracts and Total Budget (less participant stipends listed below)	$515,000
Advance OC	$5,000

Entity	Amount
Afghan American Muslim Outreach	$5,000
American Academy of Pediatrics	$5,000
Beyond Blindness	$5,000
Cancer Kinship	$5,000
Cuautla Los Hijos Ausentes	$5,000
Give For A Smile	$5,000
Hart Community Homes	$5,000
Hope Community Services	$5,000
Hub for Integration, Reentry & Employment (H.I.R.E)	$5,000
Illumination Institute	$5,000
Integrated Solutions 360 (Global Hope)	$5,000
Kalaya's Destiny	$5,000
Korean American Center	$5,000
Learning Rights Law Center	$5,000
Mercy Health	$5,000
Olive Community Services, inc.	$5,000
OneOC, in partnership with GREEN-MPHA	$5,000
Orange County Children Therapeutic Arts Center	$5,000
Orange County Chinese Community Service	$5,000
OutCare, in partnership with Pear Suite	$5,000
Pacific Islander Health Partnership	$5,000
Peer Voices of Orange County	$5,000
Project Self-Sufficiency	$5,000
Qazizada Multicultural Therapy Clinic	$5,000
Recovery Road, Inc.	$5,000
Sabil USA	$5,000
Sacred Path Indigenous Wellness Center	$5,000
Shanti Orange County	$5,000
SonRise Community Christian Church	$5,000
Straight Talk Clinic, Inc.	$5,000
The Cambodian Family	$5,000
The John Henry Foundation	$5,000
The Kennedy Commission	$5,000
Unidos South OC	$5,000
Urban Social Services and Advocacy	$5,000
Vital Access Care Foundation	$5,000
Total	$10,880,000

HOUSING AND HOMELESSNESS INCENTIVE PROGRAM

HHIP PROGRESS REPORT
WINTER 2024

CalOptima Health

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WHAT IS HHIP?

The Housing and Homelessness Incentive Program (HHIP) was a voluntary incentive program offered by the California Department of Health Care Services (DHCS). HHIP allowed Medi-Cal managed care plans (MCPs) to earn incentive funds for improving health outcomes and access to whole person care services by addressing homelessness and housing insecurity as social drivers of health and health disparities. It was directly tied to CalAIM, California Advancing and Innovating Medi-Cal, the statewide effort to expand the Medicaid program.

A Critical Component of CalAIM

HHIP drove local investments that helped spur community-based organizations to participate in CalAIM as new service providers, connecting members to new services and benefits.

TIMELINE OF PARTICIPATION

APRIL 2022	**LETTER OF INTENT SUBMITTED** Indicated to DHCS our election to participate	NO RELATED INCENTIVE
JUNE 2022	**LOCAL HOMELESSNESS PLAN SUBMITTED** In collaboration with the Continuum of Care	INCENTIVE EARNED **$4.19M of $4.19M**
SEPT 2022	**INVESTMENT PLAN SUBMITTED** Approved by the Board of Directors to drive investments in the community	INCENTIVE EARNED **$8.38M of $8.38M**
FEB 2023	**MEASUREMENT 1 SUBMITTED** Baseline setting and reporting on initial achievements	INCENTIVE EARNED **$22.28M of $29.3M**
DEC 2023	**MEASUREMENT 2 SUBMITTED** Reporting on achievements after 10 months	INCENTIVE EARNED **$38.08M of $41.9M**
MARCH 2024	**END OF PROGRAM**	

Incentives were typically drawn down a few months after the related submission.

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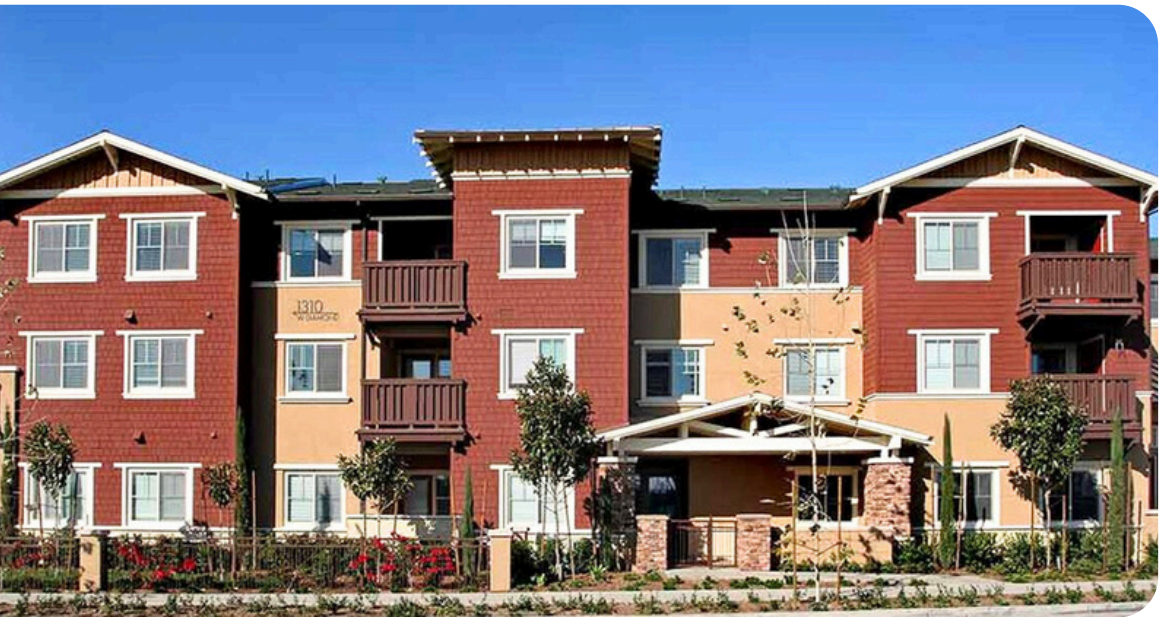


OUR LOCAL HOMELESSNESS PLAN (LHP): A ROADMAP FOR SUCCESS

NEEDED APPROACH IDENTIFIED IN THE LHP	RESULTING SUCCESSES T0-DATE
Boost regional coordination and engagement to enhance linkages to housing and services.	Four county-wide systems change grants awarded and increased collaboration with Continuum of Care.
Increase street-based case management, physical and behavioral healthcare, and housing navigation.	Launched street medicine in three cities and purchased a recovery center.
Better identify those at-risk of homelessness and experiencing homelessness through the Point-in-Time Count .	Funded PIT survey and the count; and had CalOptima leadership participation.
Provide navigation and tenancy services to support individuals in identifying and sustaining housing.	Onboarded 70+ housing navigation providers and funded the Whatever it Takes Program.
Work closely with landlords to provide deposits for damage claims, unit holding fees, and incentives.	534 Individuals served through “Whatever it Takes,” which included property owner incentives.
Expand diversion and prevention resources.	Funded Anaheim-based diversion program and “Whatever it Takes” prevention services.
Develop equity strategies targeted at populations disproportionately impacted by homelessness.	18 community-based organizations received Equity Grants.

OUR INVESTMENT STRATEGY

CalOptima Health secured $72.9 million of the $83 million dollars it was eligible for through the DHCS HHIP initiative. In addition, CalOptima Health's Board of Directors committed $87.4 million to support these efforts. The total $160.3 million is being invested in the community using the following strategy:

	AMOUNT COMMITTED	AMOUNT INVESTED	AMOUNT TO BE INVESTED
PRIORITY 1. Delivery of services and member engagement	$3.6M	$3M	$600,000
PRIORITY 2. Infrastructure to coordinate and meet member housing needs	$9.8M	$9.4M	$400,000
PRIORITY 3. Partnerships and capacity to support referrals (capital)	$98.3M	$93.3M	$5M
PRIORITY 4. Innovation and implementation of strategic interventions	$10.88M	$10.88M	$0
AMOUNT YET TO BE COMMITTED TO A PRIORITY	$37.73M	$0	$37.73M
TOTAL	**$160.3M**	**$116.58M**	**$43.73M**

Amounts yet to be granted are planned for distribution in 2025.

HHIP COMMUNITY INVESTMENTS

Presented on the following pages are the organizations that have been awarded grant funding to support executing our HHIP Priorities. Each grant award has a well-defined scope of work, SMART objectives and is actively managed by the CalAIM grants team to ensure outcomes for our members and the community.

$3.0 MILLION GRANTED

PRIORITY 1. DELIVERY OF SERVICES AND MEMBER ENGAGEMENT

These organizations were provided funding to help coordinate services across our system through the continuum of care and to ensure we receive feedback directly from our members receiving these services.

GRANTEES	AWARD AMOUNT
Office of Care Coordination; Continuum of Care	$2,200,000
Pulse for Good (Total Project)	$800,000

Pulse for Good Participants (included in the budget above):

Access California Services	$30,000	Lutheran Social Services of Southern California	$30,000
Advanced Healthcare Administration	$30,000	Mercy House	$30,000
Collette's Children's Home	$30,000	Orange County Asian and Pacific Islander Community Alliance	$30,000
Families Forward	$30,000	PATH	$30,000
Family Assistance Ministries	$30,000	Pathways of Hope OC	$30,000
Family Promise OC	$30,000	South County Outreach	$30,000
Friendship Shelter	$30,000	The Hub Resource Center	$30,000
HIS-OC	$30,000	The Salvation Army	$30,000
Illumination Foundation	$30,000	Thomas House Family Shelter	$30,000
Korean Community Services	$30,000	WISEPlace	$30,000
Leading Purpose	$30,000		

PRIORITY 2. INFRASTRUCTURE TO COORDINATE AND MEET MEMBER HOUSING NEEDS

These organizations were supported to build their organizational capacity to provide housing-related supportive services. They generally received awards under our capacity building and equity funding opportunities.

$9.4 MILLION GRANTED

GRANTEE	AWARD AMOUNT
Access California Services	$498,427
Advance OC	$100,000
AIDS Services Foundation OC, aka Radiant Health Center	$474,490
Alianza Translatinx	$221,600
Asian American Senior Citizens Service Center	$300,000
City of Anaheim	$200,000
Colette's Children's Home	$350,000
Community Action Partnership of Orange	$79,203
Families Forward	$275,128
Family Assistance Ministries (FAM)	$350,000
Family Promises of OC	$300,000
Friendship Shelter	$197,608
Grandma's House of Hope	$80,000
Grandma's House of Hope	$50,000
Homeless Intervention Services of OC	$370,000
Latino Health Access (LHA)	$500,000

GRANTEE	AWARD AMOUNT
Lutheran Social Services of Southern California	$250,000
My Safe Harbor, Inc.	$100,000
OC Family Justice Center Foundation	$82,860
OC United Together, Inc.	$100,000
Orange County United Way	$1,588,215
PATH	$883,637
Pathways of Hope	$280,000
Shelter Providers of Orange County, Inc., DBA HomeAid Orange County	$100,000
South County Outreach	$130,000
Southland Integrated Services	$450,000
StandUp for Kids	$198,024
The Eli Home, Inc.	$175,000
The Kennedy Commission	$100,000
Thomas House Family Shelter	$254,033
Vital Access Care Foundation (VACF)	$100,000
WISEPlace	$315,400

PRIORITY 3. PARTNERSHIPS AND CAPACITY TO SUPPORT REFERRALS

These organizations were provided funding for capital projects that helped to build out the county's stock of affordable, transitional and permanent supportive housing. Ultimately, the effort was to ensure our partners had the housing resources needed to serve our members.

$93.3 MILLION GRANTED

GRANTEE	AWARD AMOUNT
American Family Housing	$2,951,660
Anaheim Housing Authority	$3,878,420
C&C Development	$8,000,000
Casa Youth Shelter	$4,000,000
City of Anaheim - Housing and Community Development Department	$1,500,000
City of Anaheim/Anaheim Housing Authority	$2,000,000
City of Brea	$6,028,492
City of Yorba Linda	$3,100,000
Community Action Partnership of Orange	$98,340
Community Development Partners	$8,000,000
Families Forward	$2,500,000
Friendship Shelter	$3,850,000
Golden State Recuperative Care, Inc.	$3,500,000
Hart Community Homes, Inc.	$4,000,000

GRANTEE	AWARD AMOUNT
Illumination Foundation	$3,000,000
Jamboree Housing Corporation	$4,721,241
Kingdom Causes dba City Net	$1,337,170
Korean Community Services dba KCS Health Center	$2,500,000
Mercy Housing California	$1,500,000
Mind OC/Be Well OC	$5,000,000
National Community Renaissance of California	$1,334,677
Orange County Housing Finance Trust	$4,000,000
Pathways of Hope	$1,500,000
Shelter Providers of Orange County, Inc., DBA HomeAid Orange County	$1,400,000
The Eli Home, Inc	$5,000,000
The Illumination Foundation	$3,500,000
The Salvation Army Orange County	$4,100,000
WISEPlace	$1,000,000

PRIORITY 4. SYSTEMS CHANGE

These organizations were provided funding for systems change projects that could have county-wide impact on improving our continuum of services. This included support for the Nonprofit Health Care Academy, with a goal of broadening the organizations ready to partner with the health care system.

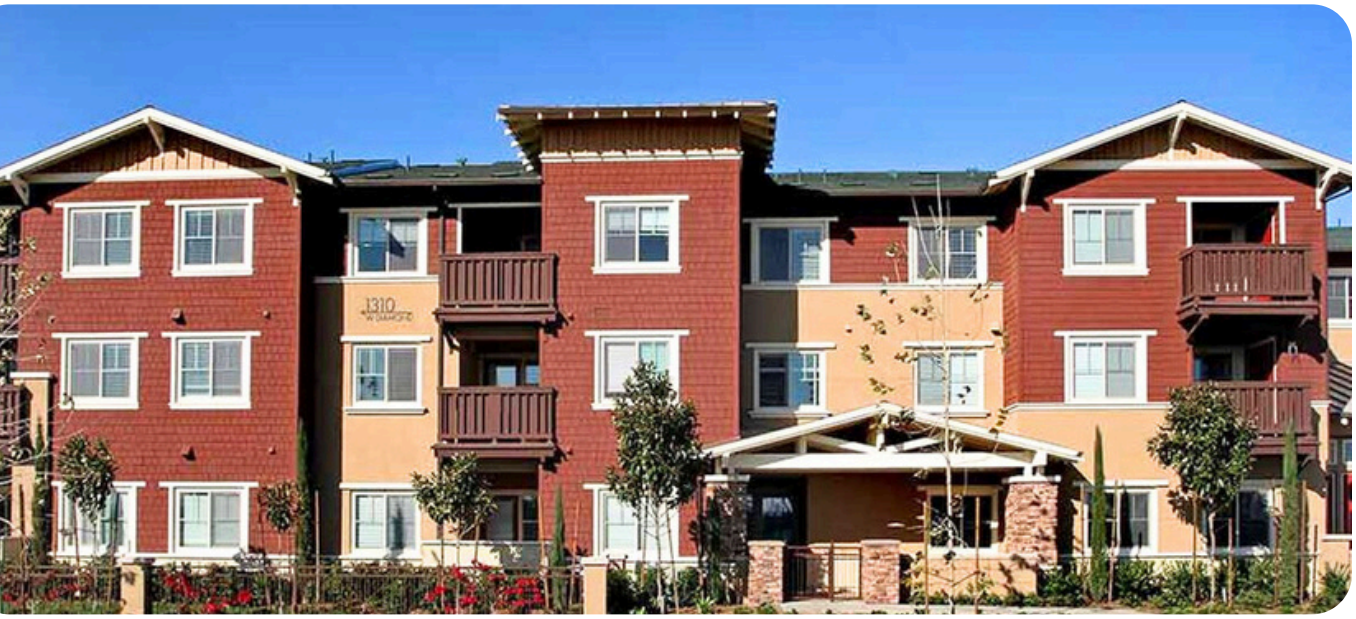
$10.88 MILLION GRANTED

GRANTEE	AWARD AMOUNT
Jamboree Housing Corporation	$3,000,000
Multi-Ethnic Collaborative of Community Agencies (MECCA)	$2,052,073
Nonprofit Healthcare Academy (Total Project Budget)	$700,000
Orange County Housing Finance Trust	$3,000,000
Project Hope Alliance	$2,127,927

Nonprofit Healthcare Academy Participants (included in the budget above):

Nonprofit Healthcare Academy Cohort 1	
Give For A Smile	$5,000
Integrated Solutions 360 (Global Hope)	$5,000
Hart Community Homes	$5,000
Hope Community Services	$5,000
Hub for Integration, Reentry & Employment (H.I.R.E)	$5,000
Illumination Institute	$5,000
The John Henry Foundation	$5,000
Korean American Center	$5,000
Olive Community Services, Inc.	$5,000
Orange County Chinese Community Service	$5,000
Peer Voices of Orange County	$5,000
Qazizada Multicultural Therapy Clinic	$5,000
Sabil USA	$5,000
Shanti Orange County	$5,000
SonRise Community Christian Church	$5,000
Straight Talk Clinic, Inc.	$5,000
The Cambodian Family	$5,000
Urban Social Services and Advocacy	$5,000
Vital Access Care Foundation	$5,000

Nonprofit Healthcare Academy Cohort 2	
Afghan American Muslim Outreach	$5,000
American Academy of Pediatrics	$5,000
Beyond Blindness	$5,000
Cuautla Los Hijos Ausentes	$5,000
Kalaya's Destiny	$5,000
Orange County Children Therapeutic Arts Center	$5,000
Pacific Islander Health Partnership	$5,000
Project Self-Sufficiency	$5,000
Sacred Path Indigenous Wellness Center	$5,000
The Kennedy Commission	$5,000
Unidos South OC	$5,000
Recovery Road, Inc.	$5,000
Advance OC	$5,000
Mercy Health	$5,000
Cancer Kinship	$5,000
Learning Rights Law Center	$5,000
OneOC, in partnership with GREEN-MPHA	$5,000
OutCare, in partnership with Pear Suite	$5,000



RESULTING OUTPUTS

1,220
HOUSING UNITS BUILT/RENOVATED

121+
STAFF POSITIONS SUPPORTED TO GROW ORGANIZATIONAL CAPACITY

96
LOCAL COMMUNITY-BASED ORGANIZATIONS FUNDED

62
NEW PROJECTS AND SERVICES LAUNCHED

2034
GRANT-FUNDED WORK WILL CONTINUE FOR MANY YEARS TO COME

113
NEW CALOPTIMA HEALTH PROVIDERS CONTRACTED TO PROVIDE CRITICAL SERVICES

CATALYSTS OF CHANGE: **MEDI-CAL TRANSFORMATION**

CalOptima Health, guided by California's Department of Health Care Services, is transforming Medi-Cal to ensure that Californians get the care they need to live healthier lives. Medi-Cal members now have access to new and improved services to get well-rounded care that goes beyond the doctor's office or hospital and addresses all of their physical and mental health needs. In the past two years, CalOptima Health has expanded it's provider network to include more than 120 community-based organizations to conduct this important work. Our community investments, in large part through HHIP, have supported these organizations to expand and evolve to conduct this work in partnership with us.

RESULTING IMPACT

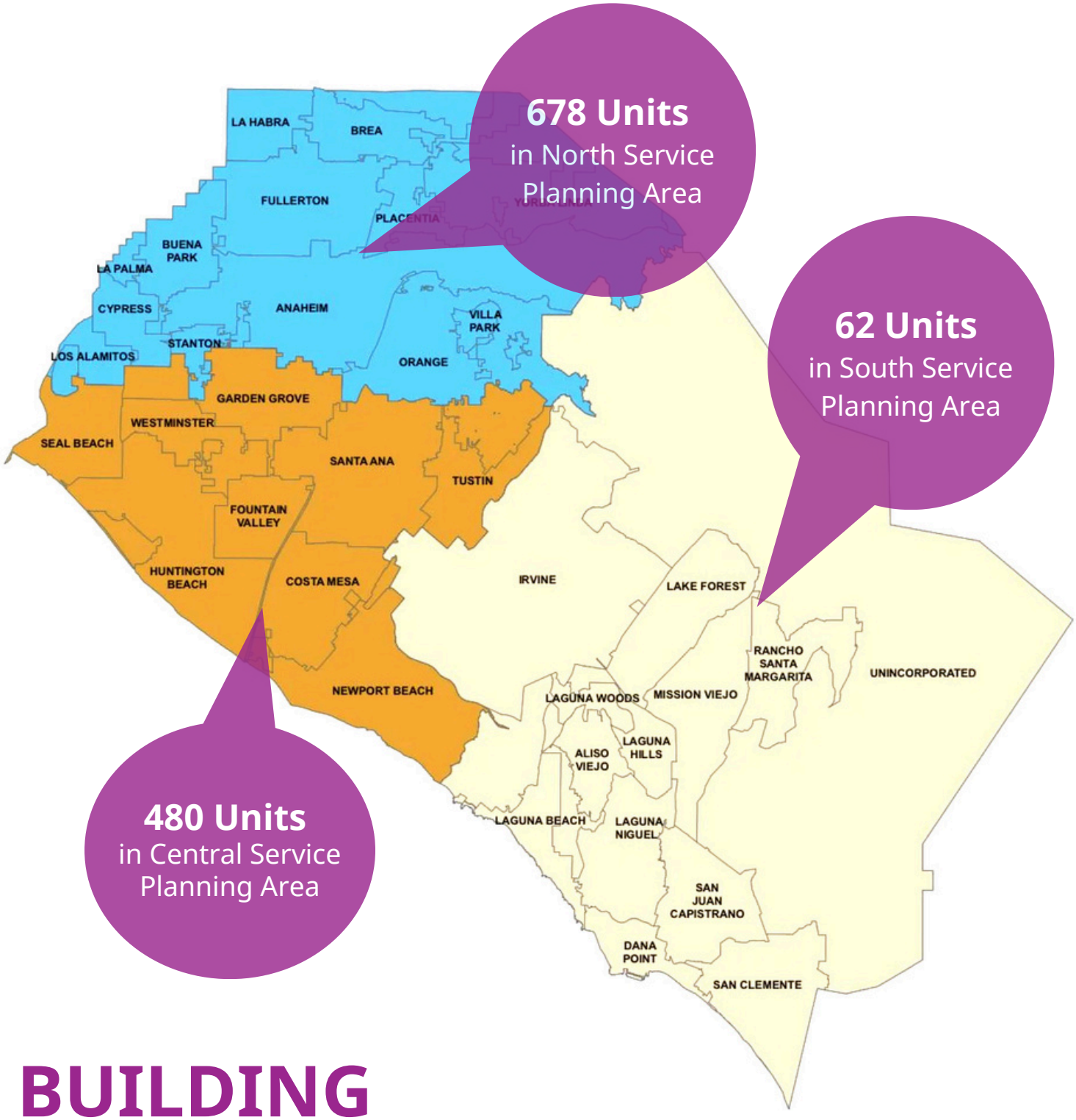
1 IN EVERY 3 PEOPLE HOUSED WERE STILL HOUSED 2+ YEARS LATER*

28% OF CALOPTIMA HEALTH'S UNHOUSED MEMBERS WERE HOUSED**

2,522 CALOPTIMA HEALTH MEMBERS HAVE SECURED HOUSING WITH THE HELP OF A HOUSING DEPOSIT

10,651 CALOPTIMA HEALTH MEMBERS HAVE RECEIVED HOUSING NAVIGATION TO ASSIST THEM IN SECURING A PERMANENT HOME

*Data reflects those housed within the first few months of the HHIP Program.
**Based on data reported in the second measurement submission (reflecting Jan - Oct 2023) and compared to the baseline of 4.7%.



BUILDING OUR WAY OUT OF A CRISIS

CalOptima Health has invested in the development and refurbishment of affordable, permanent supportive and interim housing units. Too many of our neighbors and members have been priced out of living in the community where they live and work. We are committed to increasing the stock of affordable units in our county.

PROJECT SPOTLIGHT: THE SALVATION ARMY'S CENTER OF HOPE

The Center of Hope is a comprehensive solution that combines a 325-bed, low- barrier emergency shelter with 72 permanent supportive housing apartments, onsite medical and dental care alongside an award-winning 175-bed drug and alcohol rehabilitation center. CalOptima Health contributed to the construction of permanent supportive housing units with a $4.1 million dollar grant award through an HHIP notice of funding opportunity in 2023. The Salvation Army is also contracted as a CalAIM provider for CalOptima Health.

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PROJECT SPOTLIGHT: **ILLUMINATION FOUNDATION'S CHILDREN'S RECUPERATIVE CARE**

CalOptima Health has awarded Illumination Foundation a $3.5 million grant to acquire, renovate and expand a property in Santa Ana to serve as the nation's first children's recuperative care facility serving families experiencing homelessness. The funding for the facility is part of $25 million in community grants awarded by CalOptima Health that will be dedicated to supporting transitional housing projects. Upon project completion, the facility will have space to accommodate up to 30 individuals.

Illumination Foundation's Children and Families Recuperative Care facility will provide housing to medically vulnerable homeless children and their families. The program will also serve as a safe haven for children to recover from illness or injury following their hospital release and will address the complex challenges their families are experiencing. Illumination Foundation will create a nurturing environment for families to heal and stabilize by providing comprehensive case management, housing and trauma-informed supportive services on-site.

PROJECT SPOTLIGHT:
ORANGE COUNTY UNITED WAY "WHATEVER IT TAKES"

Whatever it Takes (WIT) is a pilot program launched in July 2023 by Orange County United Way's United to End Homelessness℠ initiative. Whatever it Takes complements the CalAIM housing suite of services and expedites the time it takes someone to connect to a home.

830

MEMBERS SUPPORTED IN THE FIRST 16 MONTHS

$1,465

AVERAGE AMOUNT NEEDED TO KEEP PEOPLE HOUSED*

235

MEMBERS WENT FROM HOMELESSNESS TO A HOME

199

MEMBERS PREVENTED FROM BECOMING HOMELESS

396

CRISIS RESOLUTION IN PROGRESS

*Often paired with Housing Deposit.

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PROJECT SPOTLIGHT:
PULSE FOR GOOD

Pulse for Good makes it possible to receive timely feedback from our members experiencing homelessness. In its first year of operations in facilities across the county, we learned about our members' experience with housing support services.

5,053

RESPONSES IN THE FIRST YEAR

4.3

OVERALL AVERAGE RATING OUT OF FIVE REVEALING GENERAL SATISFACTION

11

COMMUNITY-BASED ORGANIZATIONS CONVENING TO SHARE BEST PRACTICES

18

KIOSK LOCATIONS IN SHELTERS, FOOD BANKS AND SERVICE CENTERS

PROJECT SPOTLIGHT:
NONPROFIT HEALTH CARE ACADEMY

In January 2023, CalOptima Health staff initiated the first HHIP NOFO that included an equity grants priority geared toward smaller, grassroots, community-based organizations (CBOs) in an effort to help build their capacity to serve populations experiencing health disparities. In soliciting and reviewing these proposals, it was evident there was an opportunity to further support these organizations by providing technical assistance around how they could partner with the health care sector, position their organizations as potential service providers, and craft effective proposals that convey those concepts.

n response to this need, CalOptima Health staff sought and received the Board of Directors' (Board) approval in June 2023 to allocate $10.53 million in HHIP funding to HHIP Priority 4, Innovation and Implementation of Strategic Interventions, including $350,000 for the Nonprofit Health Care Academy. The academy was set to include a series of learning experiences, skill-building sessions, and the opportunity to receive technical assistance to prepare these organizations for contracted partnership with CalOptima Health and more broadly, the health care sector.

In November 2023, CalOptima Health staff launched the first Nonprofit Health Care Academy with 20 organizations and a contracted facilitator. Participation in the sessions was robust and organizations reported satisfaction with their experience and skills built during the program through its end in February 2024.

CalOptima Health's partnership with Consilience Group as the Academy facilitator made this project possible.

85%

OF ACADEMY GRADUATES PURSUED GRANTS OR CONTRACTS WITHIN TWO MONTHS OF GRADUATION

LESSONS LEARNED

CalOptima Health hosted a series of five listening sessions in the months of August and September 2024 to gauge the community's opinions and perspectives on HHIP investments so far. Further, with potential future funding opportunities on the horizon, CalOptima Health solicited input on what those investment priorities should be. Input resulted in the following high level insights:

- **Special populations need tailored services**: Subgroups, particularly seniors, immigrant families, and LGBTQIA+ youth, were repeatedly highlighted.
- **Solutions are needed to repair a fragmented system**: Consistent feedback indicated a fragmented continuum of services available to those individuals at-risk or experiencing homelessness.
- **The housing shortage must be remedied**: The housing shortage, especially for permanent supportive housing, surfaced in every session.
- **Partnerships should continue to leverage ongoing work**: A focus on system-level solutions through cross-sector collaboration and partnerships was emphasized.
- **Flexible funding and grantmaking processes to engage smaller organizations must continue**: Grants processes that support all types of organizations were underscored as critical and should continue.
- **Advocacy and narrative change are needed to continue pushing this work forward**: These efforts are critical for movement building and long-term success.
- **More focus is needed on prevention efforts:** The County will never solve the issue without slowing the flow of residents falling into homelessness.


Promise, Peril &
Opportunity
An inflection point for providers and partnerships committed to advancing health equity
CalOptima Health

CalOptima Health is seeking to allocate $19.73 million of its final HHIP incentive payment. Based on community feedback from the recent listening sessions, CalOptima Health is committed to maintaining its four successful priority areas and will offer specific grant opportunities reflective of common feedback themes emerging from the listening sessions:

- **Priority 1.** No new dollars will be committed, however, continued investments to current projects will be made utilizing funds that already exist in that category. Specifically, member engagement will support the continued development of **tailored services for special populations**.

- **Priority 2.** **Flexible funding and grantmaking processes to engage smaller organizations** will continue with new investments to continue supporting organizations that also provide **tailored services for special populations**, **conduct advocacy and narrative change**, and **work to repair a fragmented system**.

- **Priority 3.** New dollars will be allocated to support both capital improvements of affordable and permanent supportive housing sites to **remedy the housing shortage**.

- **Priority 4.** New dollars will be allocated to support systems change projects that **focus on prevention of homelessness** for our neighbors that are at risk of this crisis, but also projects that highlight **partnerships that leverage ongoing work** and those that **work to repair a fragmented system**.

NEXT STEPS

CalOptima Health is seeking to allocate $19.73 of its remaining HHIP incentive funds. Staff will be presenting the following recommendations to the Board of Directors at the December 2024 meeting.

	COMMITTED	INVESTED	NEWLY COMMITTED	TO BE INVESTED
PRIORITY 1. Delivery of services and member engagement	$3.6M	$3M	$0	$600,000
PRIORITY 2. Infrastructure to coordinate and meet member housing needs	$9.8M	$9.4M	$600,000	$1M
PRIORITY 3. Partnerships and capacity to support referrals (capital)	$98.3M	$93.3M	$10M	$15M
PRIORITY 4. Innovation and implementation of strategic interventions	$10.88M	$10.88M	$9.13M	$9.13M
AMOUNT TO BE COMMITTED AT A FUTURE DATE	$0	$0	$0	$18M
TOTAL	**$122.58M**	**$116.58M**	**$19.73M**	**$43.73M**

Amounts yet to be invested are planned for distribution in future notice of funding opportunities.

CalOptima Health

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

22. Approve Actions Related to Mobile Screening Services

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions

1. Authorize the Chief Executive Officer, or designee, to negotiate and execute a contract amendment with Alinea Imaging Associates, Inc. to resume mobile screening services at CalOptima Health community events for the CalOptima Health Community Network Medi-Cal and OneCare members, effective no earlier than January 1, 2025.
2. Authorize the Chief Executive Officer, or designee, to negotiate and execute contracts with qualified mobile screening service providers.

Background and Discussion

Breast cancer is the second leading cause of death among women in Orange County. Health data shows that Black, Asian American, and Latina women in Orange County who have breast cancer are diagnosed later, and are more likely to die, than white women. About 1 in 4 women ages 40 and older in Orange County has not had a mammogram in the past two years. Data shows that an earlier diagnosis of breast cancer means the disease can be treated before it reaches a critical late stage.

Alinea Imaging Associates, Inc. (Alinea) is a mobile diagnostic provider offering mobile screening mammography, x-ray, and ultrasound services to individuals in Los Angeles and Orange Counties. Alinea currently provides breast cancer screening services to CalOptima Health Community Network (CHCN) members under a contract that started October 1, 2017.

In order to better support and increase quality and access to breast cancer screening services for CalOptima Health members, staff request authority to amend the contract with Alinea to update payment terms and revise the scope of work to provide mobile screening services at CalOptima Health sponsored health fairs and community events. Staff anticipate providing these services at up to 24 community events through the end of the current fiscal year. Mobile mammography services are part of a CalOptima Health quality improvement initiative to increase breast cancer screening rates. Staff have identified barriers to care, including difficulty scheduling appointments, geographic access issues, and cultural barriers. By bringing mammography into the communities where members live, CalOptima Health can address these barriers. Alinea will provide member-level reports for each screening event to track provision of mammograms and impact to breast cancer screening rates.

Staff will monitor the utilization and outcomes of the mobile screening services and continue to seek additional mobile screening service providers, as necessary. Staff will also identify opportunities to partner with other qualified mobile screening providers for contracting.

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Fiscal Impact
The recommended action to negotiate and execute a contract amendment with Alinea to provide mobile screening services at CalOptima Health community events has no additional fiscal impact on the operating budget. Staff estimates that the cost of providing these services through June 30, 2025, is $156,000.

The balance of Measurement Year (MY) 2023 Pay for Value (P4V) Performance Program unearned funds available for CCN for allocation is $1.5 million. Unearned funds from the MY 2023 P4V Performance Program will be sufficient to fund the contract amendment in the current fiscal year. Staff will include the projected expenses for mobile screening services in future operating budgets.

Rationale for Recommendation
Staff requests that the Board of Directors approve the recommended actions to ensure that CCN members have access to life-saving care offered directly to members through mobile screening services.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Covered Entities
2. Amendment to Alinea Imaging Associates, Inc. Contract

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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Attachment to the December 5, 2024, Board of Directors Meeting – Agenda 22

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED ACTION

Name	Address	City	State	Zip Code
Alinea Imaging Associates, Inc. dba Alinea Medical Imaging	2475 N. Garey Ave	Pomona	CA	91767

AMENDMENT 9 to
PHYSICIAN GROUP SERVICES CONTRACT

This Amendment No. 9 to the Professional Services Contract ("**Amendment**") is effective as of [insert date] ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima Health ("**CalOptima**"), and Alinea Imaging Associates, Inc. dba Alinea Medical Imaging ("**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 October 1, 2017, and subsequently amended eight prior times (collectively the "**Contract**"), by which Professional has agreed to provide or arrange for the provision of certain mobile diagnostic Covered Services to Members enrolled in CalOptima's Medi-Cal and OneCare programs.

B. The Parties entered into Services Agreement A027474, effective September 3, 2024 ("**Agreement**").

C. The Parties now desire to amend the Contract as provided herein to add the relevant terms from the Agreement to the Contract and to terminate the Agreement, creating one contract between the Parties.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Add Attachment A-1, *Mobile Screening Services at a CalOptima Event*, which is attached hereto and incorporated into the Contract by this reference.

2. Add Attachment B-1, *Compensation for Mobile Screening Services at a CalOptima Event*, which is attached hereto and incorporated into the Contract by this reference.

3. Terminate the Agreement as of the Amendment Effective Date, after which all obligations between the Parties shall be solely covered under the Contract.

4. 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.

5. 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.

[*signature page follows*]

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR PROFESSIONAL:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

ATTACHMENT A-1
Mobile Screening Services at a CalOptima Event

In addition to the Covered Services listed in Attachment A, Professional shall provide the Specialist Provider Covered Services detailed in this Attachment A-1. All references in Articles 1, 2, and 3 of the Contract to Attachment A shall include Attachment A as supplemented by this Attachment A-1. If any provision of this Attachment A-1 conflicts with any other provision in the Contract, the other Contract provision shall control over this Attachment A-1.

1. This Attachment A-1 shall go into effect [insert date] ("**A-1 Effective Date**").

2. Subject to the terms and conditions of the Contract, Professional shall furnish the following Covered Services to eligible Members at the sites and on the dates prior agreed to by the Parties in writing (each an "**Event**", as further described in Section 10 below):

   2D mammogram screenings (CPT 77067) ("**Mobile Screening Services**").

3. As part of providing Mobile Screening Services, Professional will:

   3.1. Provide all applicable travel, equipment setup, food, and lodging necessary for its staff to provide Mobile Screening Services to eligible Medi-Cal and OneCare Members at Events.

   3.2. Provide a qualified, State-certified radiologist to interpret the mammogram screening images for each Member who receives Mobile Screening Services at an Event.

   3.3. Timely provide reports of the mammogram screening exams to each Member's primary care physician following an Event.

   3.4. Maintain medical records in accordance with applicable laws for each Member who receives Mobile Screening Services from Professional at an Event. Professional will be responsible for the storage, maintenance, and confidentiality of such records.

   3.5. Provide a State-licensed mammography technologist to perform each of the Mobile Screening Services procedures for Members at an Event.

   3.6. Maintain all applicable certifications, licenses, and registrations necessary to render Mobile Screening Services, including those required by the American College of Radiology, the Mammography Quality Standards Act, and the U.S. Food and Drug Administration.

   3.7. Provide education and marketing support pertaining to the value of preventive mammogram screenings to Members who attend an Event.

   3.8. For non-eligible Members or non-Members who attend an Event, contract with the non-eligible Members or non-Members and/or third-party payors for screening services and be solely responsible for billing and collection of all patient fees and third-party payor reimbursement for procedures rendered to non-eligible Members and non-Members. CalOptima shall have no liability and no reimbursement obligation for any services rendered by Professional to non-eligible Members or non-Members.

3.9. Provide a toll-free number and/or online link for individuals who receive Mobile Screening Services at an Event to schedule a follow-up appointment with Member's primary care physician.

4. At each Event, Professional will make best efforts to see as many patients as possible beyond the allotted time slot in order to see all CalOptima-approved Members who wish to be screened. Walk-in patients are welcome, at CalOptima's discretion.

5. CalOptima shall pay Professional for Mobile Screening Services rendered at an Event as provided in Attachment B-1.

6. Professional shall provide Event information to CalOptima, including flyers, for the purpose of marketing events to Members.

7. CalOptima shall provide adequate space and a suitable area at each Event for Professional to provide Mobile Screening Services, as reasonably specified by Professional in advance of each Event. The parking space for Professional's mobile coach must be level, free of trees and other structures, and coned off. If a parking permit is required, CalOptima must provide contact information to Professional to obtain that permit prior to each Event. Bathroom access is required for Professional staff thirty (30) minutes prior to each Event start time and throughout the day of each Event.

8. Professional requires a minimum set up time at each Event location of one (1) hour and may require additional time depending upon the Event location.

9. CalOptima must provide a contact name and cell phone number for Professional staff in case of questions about set up at an Event arise.

10. The Parties will schedule Events at least four (4) weeks in advance, though additional lead time may be required to schedule events during October; provided, the Parties may agree in writing to a shorter schedule on an event-by-event basis.

11. Either Party may terminate this Attachment A-1 upon sixty (60) days' prior written notice to the other Party. Such termination shall also terminate Attachment B-1 but shall not terminate the Contract or its other attachments.

ATTACHMENT B-1
Compensation for Mobile Screening Services at a CalOptima Event

1. This Attachment B-1 shall go into effect as of the A-1 Effective Date.

2. CalOptima shall reimburse Professional for Mobile Screening Services rendered by Professional to eligible Members at an Event as follows:

   2.1. A full day minimum of [redacted] for thirty (30) 2D mammogram screenings (CPT 77067) regardless of the number of screenings provided by Professional at that Event.

   2.2. [redacted] for each additional 2D mammogram screening (CPT 77067) after the first thirty (30) 2D mammogram screenings at an Event.

   2.3. A [redacted] fixed event fee for each Event.

   2.4. Travel expenses of [redacted] per mile for each Event, measured from Professional's 2475 N. Garey Ave, Pomona, CA 91767 address to the Event; provided, however, the Parties shall agree in writing in advance if Professional intends to use more than one vehicle for an Event.

   2.5. A [redacted] cancellation fee if CalOptima cancels any Event within twenty-one (21) days of the scheduled Event.

3. CalOptima shall pay the undisputed amounts owed under Section 2 within thirty (30) days of receipt of Professional's invoice.

4. Professional shall invoice CalOptima the month following each Event. The Parties agree that the fees set forth in this Attachment B-1 are reasonable and constitute liquidated damages, not a penalty. CalOptima's obligation to pay fees under this Attachment B-1 shall not be dependent upon CalOptima's billing and collection of Member and/or third-party payor accounts receivable.

5. One year after the A-1 Effective Date and no more than annually thereafter, Professional may increase fees under Section 2 by an amount equal to the lesser of the prior twelve (12)-month increase in the U.S. Bureau of Labor Statistics ("**BLS**") Employment Cost Index for "Service-providing industries: Health care and social assistance (not seasonally adjusted, total compensation)" or any replacement index as determined by BLS or [redacted]. Professional shall provide CalOptima at least sixty (60) days' prior written notice of any such fee increase.

6. The payment procedures and requirements in Attachment B shall control reimbursement under this Attachment B-1 unless those requirements in Attachment B directly conflict with the provisions in Attachment B-1.

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

23. Authorize Action Related to the Medi-Cal Fee for Service Hospital Services Contract with University of California, Irvine – UCI Health Placentia-Linda

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions

1. Authorize unbudgeted expenditures in the amount of $900,000 from existing reserves to support the transition to Board-approved reimbursement rates and payment methodologies effective on or after January 1, 2025, for University of California, Irvine – UCI Health Placentia-Linda.

Background and Discussion

On May 2, 2024, the CalOptima Health Board of Directors (Board) approved the sunsetting of the temporary post-Public Health Emergency supplemental funding program, effective for dates of service on and after July 1, 2024. In addition, the Board made a commitment to increase provider rates over a period of thirty (30) months, beginning July 1, 2024, for certain contracted Medi-Cal providers. Through these actions, the Board approved inpatient and outpatient rate increases for Fee-for-Service Hospitals.

On June 6, 2024, the Board authorized CalOptima Health to execute amendments to the CalOptima Health Medi-Cal Fee-for-Service Hospital Services contracts to update rates for inpatient hospital services when contracted at All Patients Refined Diagnosis Related Groups (APR-DRG) rates, and update rates for certain outpatient hospital claims.

Pursuant to the June 2024 Board action, staff worked with University of California, Irvine – UCI Health Placentia-Linda to update the payment methodology including the change from per diem to APR-DRG for hospital services. This recommended action is for unbudgeted expenditures to implement these changes, effective on or after January 1, 2025.

Fiscal Impact

The recommended action is an unbudgeted item. The estimated annual net fiscal impact is approximately $1.8 million, or $900,000 for the period of January 1, 2025, through June 30, 2025. An appropriation of up to $900,000 from existing reserves will fund the recommended action through June 30, 2025. Staff will include expected expenditures in future operating budgets.

Rationale for Recommendation

Approval of the recommended Board action will allow CalOptima Health to maintain its robust hospital network and provide continued access to CalOptima Health's Medi-Cal members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Entities Covered by this Recommended Action

Board Actions

Board Meeting Dates	Action
June 6, 2024	Authorize the Chief Executive Officer to execute amendments to the CalOptima Health Medi-Cal Fee-for-Service Hospital Services Contracts to: 1. Update rates for inpatient hospital services when contracted at All Patients Refined Diagnosis Related Groups (APR-DRG) rates, effective July 1, 2024. 2. Update rates for certain outpatient hospital claims, effective July 1, 2024. 3. Add language to operationalize a payment methodology to comply with the Department of Health Care Services mandatory targeted rate increases, effective January 1, 2024.
May 2, 2024	1. Direct the Chief Executive Officer, or designees, to make a commitment of up to $526 million from undesignated reserves to support provider rates to ensure longer-term provider network stability, network adequacy, and access to care for CalOptima Health members throughout Orange County; and 2. As part of this initiative, authorize the Chief Executive Officer, or designees, to develop and implement rate increases to contracted fee for service hospitals to be implemented July 1, 2024, through December 31, 2026; and 3. Sunset the temporary, short-term supplemental Medi-Cal payment increases of up to 7.5% for contracted fee for service hospitals to support expenses for services provided to members during the transition out of the Public Health Emergency, effective for dates of service on and after July 1, 2024.

/s/ Michael Hunn — **Authorized Signature**

11/27/2024 — **Date**

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Attachment to the December 5, 2024, Board of Directors Meeting – Agenda Item 23

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
University of California, Irvine *dba* UCI Health – Placentia Linda	1301 N. Rose Dr.	Placentia	CA	92870

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
24. Election of Officers of the Board of Directors for Terms Beginning January 1, 2025

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

Recommended Action
Elect the Chair and Vice Chair of the Board of Directors for terms effective January 1, 2025, through the last day of the month of the next organizational meeting, or until the election of a successor(s), unless the Chair or Vice Chair shall sooner resign or be removed from office.

Background/Discussion
In accordance with Article VIII, Section 8.1 of CalOptima Health's Bylaws, the Board of Directors (Board) shall elect one of its Directors as Chair at an organizational meeting. The Chair shall be the principal officer of the Board, shall preside at all meetings of the Board, and shall appoint all members of the Ad Hoc Committees, as well as the chair of the Ad Hoc Committees and all Committees other than the Member and Provider Advisory Committees. The Chair shall perform all duties incident to the office and such other duties as may be prescribed by the Board from time to time.

Section 8.2 of the CalOptima Health Bylaws states that the Board shall elect one of its Directors to serve as Vice Chair at an organizational meeting. The Vice Chair shall perform the duties of the Chair if the Chair is absent from the meeting or is otherwise unable to act.

The Chair and Vice Chair terms shall commence on the first day of the month after the organizational meeting at which they are elected to their respective positions.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The recommended actions are in accordance with Article VIII of the CalOptima Health Bylaws.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Ballot for Election of Chair
2. Ballot for Election of Vice Chair

/s/ Michael Hunn *11/26/2024*
Authorized Signature **Date**

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BOARD OF DIRECTORS' ELECTION OF OFFICERS

CALENDAR YEAR 2025

VOTING BALLOT

CHAIR

VOTING DIRECTOR'S NAME: _____

	DIRECTOR NOMINATION
	ISABEL BECERRA

BOARD OF DIRECTORS' ELECTION OF OFFICERS

CALENDAR YEAR 2025

VOTING BALLOT

VICE CHAIR

VOTING DIRECTOR'S NAME: _____

	DIRECTOR NOMINATION
	VICENTE SARMIENTO

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