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

DECEMBER 4, 2025
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

Isabel Becerra, Chair
Maura Byron
Blair Contratto
Catherine Green, R.N.
Veronica Kelley, DSW, LCSW
Supervisor Vicente Sarmiento, Vice Chair
Supervisor Doug Chaffee
Norma García Guillén
Brian Helleland
José Mayorga, M.D.
Supervisor Janet Nguyen, Alternate

CHIEF EXECUTIVE OFFICER
Michael Hunn

OUTSIDE GENERAL COUNSEL
Troy R. Szabo
Kennaday Leavitt

CLERK OF THE BOARD
Sharon Dwiers

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

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

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

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at
https://us02web.zoom.us/webinar/register/WN_TB7QbOYFQ86tWfraIaHslw
Join the Meeting.
Webinar ID: **885 6751 8872**
Passcode: **446830** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
1. School Behavioral Health Incentive Program – 2022-2024 Final Report

MANAGEMENT REPORTS
2. Chief Executive Officer Report

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

CONSENT CALENDAR
3. Minutes
   a. Approve Minutes of the November 6, 2025 Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the June 18, 2025 Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee

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

5. Approve the New CalOptima Health Policy GA.8064

6. Authorize Amendments to CalOptima Health's Primary and Secondary Agreements with the California Department of Health Care Services Related to Calendar Year 2026 Final Draft Rate Updates

7. Ratify Actions Related to Federal Shutdown Response Supplemental Food Support for CalOptima Health Members

8. Receive and File Closed and Open Board Ad Hoc Committees

9. Approve Actions Related to Requesting Additional Funds for the Member and Population Health Needs Assessment

10. Receive and File:
    a. October 2025 Financial Summary
    b. Compliance Report
    c. Government Affairs Reports
    d. CalOptima Health Community Outreach and Program Summary

REPORTS/DISCUSSION ITEMS

11. Approve Actions Related to CalOptima Health's Hospital Services Contracts with Acute Care Hospitals for Medi-Cal, OneCare, Program of All-Inclusive Care for the Elderly, and Covered California Programs

12. Approve Modifications to Policy EE.1116, Contracted Provider Notification to CalOptima Health of Changes Affecting the Legal Status of the Contract

13. Approve the CalOptima Health Measurement Year 2026 Medi-Cal and OneCare Pay for Value Programs and Measurement Year 2027 Covered California Pay for Value Program

14. Approve Material Change to Grant Award Agreement with Coalition of Orange County Community Health Centers for Population Health and Value-Based Care Transformation

15. Approve Actions Related to the Orange County Community Health Assessment and Community Health Improvement Plan

16. Authorize the Submission of the Letter of Intent to Apply to Covered California for Plan Year 2027

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

18. Approve the Establishment of the Legislative Committee as an Additional Standing Board Committee

19. Adopt the Proposed CalOptima Health Board of Directors, Including the Finance and Audit, Quality Assurance and Legislative Committees, Meeting Schedule Effective January 1, 2026, through December 31, 2026

20. Consider a Request to Support a Proposed Amendment to CalOptima Health's Governing Ordinance

21. Election of Officers of the Board of Directors for Terms Beginning January 1, 2026

CLOSED SESSION

CS-1. Pursuant to Government Code section 54956.87, subdivision (b) HEALTH PLAN TRADE SECRETS: PACE

CS-2. Pursuant to Government Code section 54956.9, subdivision (d)(1) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION (7 Cases)

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors on December 4, 2025 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us02web.zoom.us/webinar/register/WN_TB7QbOYFQ86tWfraIaHslw

To **Join** this webinar:
https://us02web.zoom.us/s/88567518872?pwd=ipjxY29RyIvIr14hNbxq3LsrvkfRaY.1

Phone one-tap:
+16694449171,,88567518872#,,,,*446830# US
+16699009128,,88567518872#,,,,*446830# US (San Jose)

Join via audio:
+1 669 444 9171 US
+1 669 900 9128 US (San Jose)
+1 253 205 0468 US
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
+1 719 359 4580 US
+1 312 626 6799 US (Chicago)
+1 360 209 5623 US
+1 386 347 5053 US
+1 507 473 4847 US
+1 564 217 2000 US
+1 646 558 8656 US (New York)
+1 646 931 3860 US
+1 689 278 1000 US
+1 301 715 8592 US (Washington DC)
+1 305 224 1968 US
+1 309 205 3325 US

Webinar ID: 885 6751 8872
Passcode: 446830

International numbers available: **https://us02web.zoom.us/u/kt5EaWZWF**

Student Behavioral Health Incentive Program 2022-2024 Final Report

Board of Directors Meeting

December 4, 2025

Carmen Katsarov, LPCC, CCM

Executive Director, Behavioral Health Integration

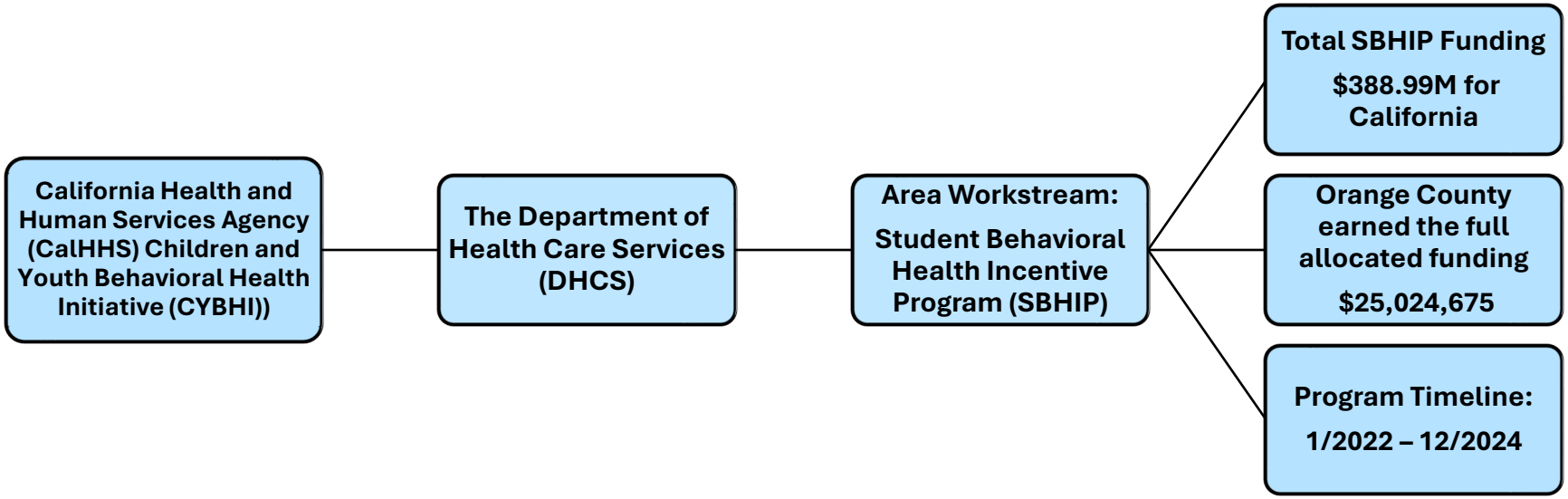
Our Mission

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

Our Vision

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

Student Behavioral Health Incentive Program (SBHIP)



SBHIP Partners Achievements

OCDE and the 28 Public School Districts

- More behavioral health personnel - increased by 38.45%
- Increased behavioral health training for school personnel
- Improved screening and referral processes
- Improved IT infrastructure and systems

Hazel Health

- 20 of 28 school districts have signed direct contracts with Hazel Health*
- More than 260,000 students now have access to telehealth services.
- More than 11,000 visits completed, including during winter, spring, and summer breaks*
- Telehealth services extended through the 2025–2026 school year.

*Update as of 11/24/25

CalOptima Health

SBHIP Partners Achievements

CHOC, part of Rady Children's Health

- Opened all 10 SBHIP-funded WellSpaces.
- Expanded their School Reintegration Program, serving 352 children (Jan–June 2025).
- Expanded Mental Health Crisis Clinic capacity; screened 127 returning students (Jan–June 2025).
- Hired a psychologist to support the deaf and hard of hearing program and offer free school consultations.
- Launched Autism Comprehensive Care Program in March 2025 for students aged 12–17 with autism and severe mental health needs.

CalOptima Health

SBHIP Partners Achievements

Western Youth Services (WYS)

- Developed an on-demand Behavioral Health Training Program for Orange County school staff, focused on trauma-informed, brain-based strategies.
- 65% of districts have accessed the training via live sessions, workshops, or the Learning Management System platform.
- WYS provides ongoing consultative support to school behavioral health staff post-training.

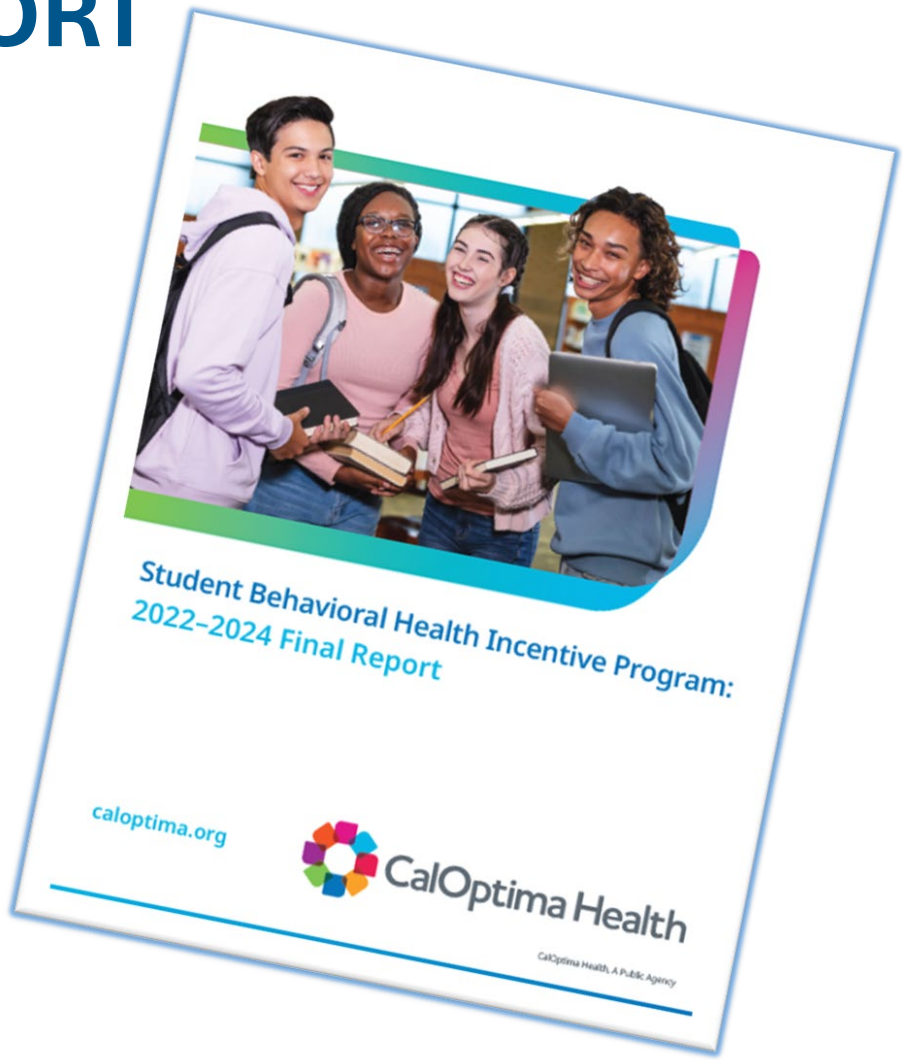
OC Health Care Agency (HCA)

- CHORUS, an external platform, was chosen to enhance data sharing between CalOptima Health and the HCA. Staff from both organizations input screening and care transition data into CHORUS, allowing real-time referral access and improving care efficiency for CalOptima Health members.

CalOptima Health

SBHIP FINAL REPORT

- Where can you find it?
  - CalOptima Health Website
    - About Us →News and Media Publications



CalOptima Health

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MEMORANDUM

DATE:	November 26, 2025
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — December 4, 2025, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; and Whole-Child Model Family Advisory Committee

A. Member and Population Health Needs Assessment Member Survey Continues

CalOptima Health's Member and Population Health Needs Assessment (MPHNA) is making significant progress. The provider survey concluded in August with 301 responses, exceeding previous assessments. Preliminary highlights will be shared at upcoming provider forums, and detailed data will be included in the final MPHNA report. The member survey began on October 16, with outreach conducted via online platforms, postcards and in-person events. So far, we have received nearly 600 responses. We have engaged internal and external stakeholders and community partners at more than 20 events to encourage member participation, as well as used community events and our Street Medicine and PACE programs to augment responses. We will continue our efforts to promote the member survey until it closes in mid-December. In addition, focus groups have been conducted for eight target populations, and three additional groups are scheduled to be completed by mid-December.

B. 2,700 Attend CalOptima Health's Open House and Thanksgiving Food Distribution

CalOptima Health hosted our second annual Open House Thanksgiving Food Distribution Event for members on Saturday, November 22, at our 505 building. CalOptima Health members received a choice of a turkey, ham or Northgate Market gift voucher (for vegetarian options), along with traditional side items. Non-members received free food boxes, provided by Second Harvest Food Bank. Members connected with various CalOptima Health departments, including Customer Service, Behavioral Health Integration, Cultural and Linguistics, PACE, OneCare, Long-Term Services and Supports, Case Management and CalAIM to learn more about our Medi-Cal programs and the supportive services we offer. On-site community partners included the County of Orange Social Services Agency (SSA) to assist with Medi-Cal and CalFresh enrollment, 211OC to connect members with community resources, and Mercy Health to provide vaccinations. This annual event reflects CalOptima Health's continued commitment to supporting the health and well-being of our members and their families.

C. Covered California Monthly Update

CalOptima Health continues to prepare for the launch of a Covered California line of business, effective January 1, 2027. Following the Board's approval on June 5, staff submitted an initial filing on June 16 to the California Department of Managed Health Care (DMHC) to expand the scope of

CalOptima Health's current Knox-Keene Act license, which is required to offer a commercial insurance product. Since then, we have engaged with DMHC on to respond to comments and provide additional information. On October 31, staff submitted our second filing, including provider network rosters. Staff continue to collaborate with our provider network and execute amendments with several existing vendors to include Covered California in their scopes of service. In addition, operational workstreams are actively working to achieve operational readiness during the next year. Our teams are also currently reviewing and developing strategies to respond to the 2027 Qualified Health Plan application in April 2026 (pending Board approval) and have engaged with Covered California's Plan Management Advisory Group to maintain alignment. Finally, staff are monitoring regulatory and policy impacts on the Marketplace landscape in California as a result of H.R. 1 to better understand risks to CalOptima Health's members as well as projected enrollment in 2027.

D. Federal Government Shutdown Ends

On November 12, U.S. President Donald Trump signed into law H.R. 5371: Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026, which reopened the federal government after a 43-day shutdown. H.R. 5371 previously passed the U.S. Senate and the U.S. House of Representatives after a bipartisan group of senators reached an agreement on an amended Continuing Resolution (CR) in exchange for a later vote in mid-December on extending the enhanced Advance Premium Tax Credits (eAPTCs) that are set to expire on December 31, 2025. The amended CR funds most of the federal government at existing levels through January 30, 2026, but also includes a "minibus" of three Fiscal Year 2026 appropriations bills (Agriculture, Legislative Branch and Military Construction-Veterans Affairs) with new full-year funding through September 30, 2026. In addition, H.R. 5371 reauthorizes several federal health care programs and allowances that had expired, such as Medicare telehealth flexibilities, community health centers, hospital-at-home program, Medicaid disproportionate share hospital payments and more. Government Affairs staff is monitoring any further developments regarding eAPTC negotiations and is advocating for at least a one-year extension to best position CalOptima Health's Covered California launch on January 1, 2027.

E. CalOptima Health Leaders Attend Washington, D.C., Advocacy Meetings

In November, Government Affairs leaders traveled to Washington, D.C., for a marathon of meetings with key Congressional staff as the federal government remained closed. In addition to meeting with all members of Orange County's federal delegation, CalOptima Health met with offices holding key positions in party leadership and on health-related committees and caucuses. In each meeting, staff provided updates on the Board's recent approval of the $19.8 million Medi-Cal Eligibility Outreach Strategy as well as $8 million in supplemental food support for our members enrolled in CalFresh. Staff also advocated for an extension of the expiring eAPTCs and requested additional flexibilities from the U.S. Centers for Medicare & Medicaid Services (CMS) regarding the implementation of H.R. 1 provisions, particularly new Medicaid work requirements.

F. OneCare Annual Enrollment Kicks Off With New Marketing and Advertising Campaign

The 2026 OneCare open enrollment season kicked off in October with a robust marketing and advertising campaign. This season, we've rolled out new and innovative strategies, including:

- New direct mail approach
    - Use of a simple, more official-looking letter
    - Direct response slip and business response envelope
    - Simplified mailing list segmentation to target the segments that had the best response rates

- New age-in campaign
    - Educational letters to assist Medi-Cal members who are aging into Medicare through their enrollment journey
    - Added supplemental flyers with more information and resources
    - Segmented reply cards to better track the success of the mailings
- Caregiver campaign
    - Direct outreach to the caregivers of prospective OneCare members (i.e., Medi-Medis), who are often the primary decision makers for prospective members.
    - Campaign headline of "Medicare + Medi-Cal That Puts Your Loved One First", with copy points that reinforce how OneCare helps caregivers by providing Medi-Medis with easier access to their health care.

Staff has seen some early successes with these new strategies, with OneCare hitting an enrollment record of 18,450 members, as well as more than doubling the response rate to the new direct mailers. In addition, we are also developing a D-SNP educational video aimed at providing a detailed explanation of how Medi-Cal and Medicare work, and positioning OneCare as the solution to help simplify health care access for Medi-Medis in Orange County. It will be used by the OneCare sales team as an educational tool and will be leveraged across multiple communication channels, including social media and our website.

G. New Public Charge Rule Proposed

On November 19, the U.S. Department of Homeland Security (DHS) published a proposed rule rescinding the 2022 Public Charge Ground of Inadmissibility regulations issued by the Biden Administration that had narrowly defined "public charge." The proposed rule has a 30-day comment period through December 19, 2025. Notably, it does not appear that DHS will pursue a new definition of public charge via the formal rulemaking process but instead will issue future guidance (without public comment) that declines to name or exempt specific programs that can be used as evidence for a public charge determination. This is expected to result in broad leeway for immigration officers to consider receipt of any public benefit — such as Medicaid (Medi-Cal) — in their determinations, potentially creating a significant chilling effect on the uptake of benefits by individuals pursuing a green card and their family members, including U.S. citizens, as well as immigrants who mistakenly believe the public charge rule applies to them. Further developments about this change will be shared as they are made available.

H. DHCS Announces PACE Application Pause and Related Changes

On November 17, the California Department of Health Care Services (DHCS) sent a policy letter to all PACE organizations announcing a pause in the PACE application process, effective from November 20, 2025, to November 19, 2027, to manage resources and growth within the program. During this period, DHCS will not accept applications for new PACE organizations or service area expansions, although it will continue to process applications already in review. On November 19, CalOptima Health submitted a Letter of Interest to add a new center within our currently approved area.

I. Update on Orange County Global Medical Center's Latest Issues

Stroke Center Designation: In early November, Orange County Global Medical Center lost its county designation as a stroke center, nearly four months after OC's Emergency Medical Services agency placed the facility on suspension following reports of poor medical care. Under county guidelines, 911 dispatchers and paramedics must route stroke patients to a stroke neurology-receiving center, bypassing other hospitals without the designation. This comes amid CalOptima Health maintaining heightened,

hands-on oversight of the hospital's quality and safety performance, with weekly meetings and a particular focus on high-risk services and infrastructure.

ICU Flooding: On November 11, CalOptima Health became aware through media reports that Orange County Global experienced flooding in its ICU following mid-October storms. The ICU was closed for remediation, and patients were safely relocated to other monitored inpatient beds. On November 13, staff initiated direct communication with hospital leadership to receive ongoing updates on ICU restoration and documentation of corrective actions. Staff is monitoring continuity of care for members requiring ICU-level services, verifying network adequacy for critical-care capacity, and conducting weekly internal reviews to track remediation progress and any potential impact on member access or safety. CalOptima Health will maintain active oversight and promptly inform the Board of any significant developments. The ICU is expected to return to full operation in early December.

J. CalOptima Health Receives Robust Media Coverage

- On November 10, CalOptima Health distributed a press release on the $8 million approved by the Board to fight food insecurity. Related news coverage includes:
  - LAist
  - The Fullerton Observer
  - OC Independent
  - MyNewsLA.com
  - NewSantaAna.com
  - Huntington Beach News
  - Spectrum News
  - KNX radio
  - The Orange County Register ran a related article about H.R. 1's impact on CalFresh and Medi-Cal.
- On November 13, the Capistrano Dispatch ran an article on the opening of allcove San Juan Capistrano, a wellness center for youth. CalOptima Health Executive Director of Behavioral Health Integration Carmen Katsarov was interviewed for the story. "It's an example of when the whole community comes together, from a managed care plan to a community organization to UC Irvine, we can deliver better results for youth," she said. "We needed to co-create something outside the traditional system to provide mental health care and prevention in a different way."

CalOptima Health

Fast Facts
December 2025

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

Membership Data* (as of October 31, 2025)

Total CalOptima Health Membership

877,802

Prior month: 885,314

Program	Members
Medi-Cal	859,055
OneCare (HMO D-SNP)	18,211
Program of All-Inclusive Care for the Elderly (PACE)	536

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

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

	Dashboard	YTD Actual	Actual vs. Budget ($)	Actual vs. Budget (%)
Operating Income/(Loss)	●	$64.4M	$50.8M	372.6%
Non-Operating Income/(Loss)	●	$39.9M	$7.1M	21.7%
Covered California Start-up Expenses	●	($1.6M)	$1.7M	52.3%
Bottom Line (Change in Net Assets)	●	$102.7M	$59.7M	138.4%
Medical Loss Ratio (MLR) *(Percent of every dollar spent on member care)*	●	91.8%	---	(1.1%)
Administrative Loss Ratio (ALR) *(Percent of every dollar spent on overhead costs)*	●	4.7%	---	1.7%

Notes:

- For additional financial details, refer to the financial packages included in the Board of Directors meeting materials.
- Adjusted MLR (without the estimated provider rate increases funded by reserves) is 90.7%.

Reserve Summary (as of October 31, 2025)

	Amount (in millions)
Board Designated Reserves*	$1,609.9
Statutory Designated Reserves	$134.6
Capital Assets (Net of depreciation)	$111.0
Unspent Balance of Allocated Resources	$381.4
Unspent Balance of Board Approved Provider Rate Increase**	$245.6
Unallocated Resources*	$420.9
Total Net Assets	$2,903.3

* Total of Board-designated reserves and unallocated resources can support approximately 183 days of CalOptima Health's current operations.

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

Total Annual Budgeted Revenue **$4.7 Billion**

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

CalOptima Health Fast Facts

October 2025

Personnel Summary (as of November 15, 2025, pay period)

	Filled	Open	Vacancy % Medical	Vacancy % Administrative	Vacancy % Combined
Staff	1,350	82.25	39.80%	60.20%	5.74%
Supervisor	83	4	25%	75%	4.6%
Manager	114	14	14.29%	85.71%	10.94%
Director	79	8.50	17.65%	82.35%	9.71%
Executive	21	1	---%	100%	4.55%
Total FTE Count	1,647	109.8	19.35%	80.65%	6.25%

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

Provider Network Data (as of November 20, 2025)

	Number of Providers
Primary Care Providers	1,289
Specialists	7,791
Pharmacies	497
Acute and Rehab Hospitals	42
Community Health Centers	70
Long-Term Care Facilities	234

Treatment Authorizations (as of September 30, 2025)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	35.96 hours
Prior Authorization – Urgent	72 hours	5.71 hours
Prior Authorization – Routine	5 days	0.69 days

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

Member Demographics (as of October 31, 2025)

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

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

Medi-Cal Aid Category	
Expansion	38%
Temporary Assistance for Needy Families	37%
Seniors	12%
Optional Targeted Low-Income Children	7%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

November 6, 2025

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on November 6, 2025, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar, as allowed under Assembly Bill 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under View Past Meeting Materials. Chair Isabel Becerra called the meeting to order at 2:05 p.m., and Director Catherine Green led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair; Supervisor Vicente Sarmiento, Vice Chair (left meeting at 5:48 p.m.); Maura Byron; Supervisor Doug Chaffee; Blair Contratto; Norma García Guillén; Catherine Green, R.N.; Brian Helleland; Veronica Kelley (non-voting) (arrived at 2:07 pm. and left the meeting at 3:35 p.m.); Jose Mayorga, M.D.

(All Board members participated in person except Director Kelley, who participated remotely under Just Cause using her second of two uses for calendar year 2025)

Members Absent: None.

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

The Clerk noted for the record that because Director Kelley is a non-voting member and all other Board members are participating in person, the Board will not need to take roll call votes.

In addition, the Clerk noted for the record that staff would like to continue Agenda Item 16 to the December Board meeting.

PRESENTATIONS/INTRODUCTIONS

1. Digital Member Communication: Texting Program Updates

Deanne Thompson, Executive Director, Marketing and Communications, provided a brief overview of CalOptima Health's texting program, which is an essential part of its digital outreach strategy. Texting helps CalOptima Health keep members informed, connected to care, and engaged in their health. Ms. Thompson noted that what began in 2023 as a Medi-Cal renewal effort has evolved into a key communications channel supporting quality, access, and engagement across CalOptima Health's organization.

CalOptima Health now reaches over 571,000 members in their preferred languages, including English, Spanish, Vietnamese, Korean, Farsi, Arabic, Chinese, and Russian. While the slide shows 388,000, that figure reflects individual phone numbers, many of which serve entire households. Ms. Thompson

reported that the campaigns include both one-way informational texts and two-way interactive messages, helping improve quality measures, increase preventive screenings, and drive attendance at health events. Since the launch, CalOptima Health has sent over 10 million text messages. Each campaign is data-driven and targeted, using eligibility, claims, and quality data to identify member cohorts – such as those with diabetes or children due for screenings. Messages are tailored by geography, timing, and language, and all content undergoes regulatory review to ensure compliance with CalOptima Health's regulators – the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) – and comply with the Health Insurance Portability & Accountability Act (HIPAA).

Ms. Thompson reported that in 2024 CalOptima Health expanded texting to support goals like medication adherence, behavioral health follow-ups, and preventive care. In 2025, it began collaborating with health networks to promote wellness visits and community events. CalOptima Health is currently running 27 active campaigns (10 one-way and 17 interactive), reaching a targetable pool of nearly 463,000 members with valid phone numbers who have not opted out of the texting campaign. She added that CalOptima Health's delivery rate is 81%, slightly below the industry benchmark of 86%, largely due to the unique challenges faced by its low-income member population such as limited data plans or service interruptions. Still, these metrics highlight the effectiveness and reliability of CalOptima Health's digital outreach.

Ms. Thompson noted that CalOptima Health uses three types of messages: One-way texts for reminders, tips and general information; two-way short message service (SMS) for quick responses or preferences; and ywo-way messages via the Invisible App, a secure web portal accessed through a text link, no download required, for a more interactive experience, while keeping the member's data encrypted and protected. Together, these tools ensure CalOptima Health reaches the right member, in the right language, at the right time.

Ms. Thompson reported that CalOptima Health's general texting campaigns focus on four key areas: Coverage and benefits, which include Medi-Cal renewal outreach and OneCare marketing; member engagement, such as outreach to discontinued Medi-Cal members and promotion of OneCare health rewards; member information, which are campaigns that prompt members to update mailing addresses, preferred languages, and contact details; and community resources, which promote local events and health fairs. Ms. Thompson added that these campaigns help keep members informed and connected while reducing administrative burdens by minimizing returned mail and missed renewals.

CalOptima Health has also begun partnering with its health networks to support member outreach. Approved campaign scripts can be shared and customized with network-specific phone numbers or URLs, and campaign lists can be segmented by network. This approach ensures aligned messaging while maintaining consistency and regulatory compliance.

Ms. Thompson and Kellen Aguilar, Communications Specialist, responded to Board members' comments and questions.

MANAGEMENT REPORTS

2. Chief Executive Officer (CEO) Report

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

Mr. Hunn reviewed the latest Fast Facts, noting that CalOptima Health shows a strong financial position,

with all indicators in the green, which Nancy Huang, Chief Financial Officer will address in more detail. He noted that CalOptima Health continues to maintain a robust provider network, and treatment authorizations remain in compliance. However, he did note that enrollment has declined since the beginning of the year, and as of September, CalOptima Health enrollment is at 885,000 individuals. Much of the decline in membership has to do with changes in health care coverage for immigrants and redeterminations.

Mr. Hunn noted that in August 107,000 renewal notices were issued by the Social Services Agency (SSA). CalOptima Health will assess trends in disenrollment or non-renewal by mid-November and early December. A key focus has been proactive communication – particularly through its texting campaign – to remind members to complete and return renewal applications promptly. The COVID-era grace period has ended, so timely action is critical, especially for children and seniors.

To support this effort, CalOptima Health is co-developing a comprehensive outreach toolkit with the Health Care Agency and SSA. This toolkit will include messaging, FAQs, posters, and social media content to guide members through Medi-Cal eligibility and re-enrollment changes over the next two years. Mr. Hunn thanked the Board for its approval of $19.8 million at the last meeting, noting that those dollars are instrumental in funding these targeted campaigns, including the "Get Care: Your Health Matters" initiative. These efforts aim to ensure members understand the evolving requirements and maintain their coverage.

Recently, CalOptima Health hosted a Community Connect meeting with nearly 200 attendees from agencies across Orange County. Presentations by leadership and the Social Services Agency helped clarify upcoming Medi-Cal changes. Additional outreach sessions are being scheduled with community organizations to continue this education.

Mr. Hunn added that as new rules under H.R. 1 are implemented, clear and early communication will be essential. The complexity of these changes requires detailed messaging and training for both members and staff. CalOptima Health is committed to staying ahead of these developments, and Mr. Hunn thanked the Board for its continued support.

Mr. Hunn provided additional updates, including the Member and Population Health Needs Assessment Member Survey launch, the federal government shutdown, CalFresh benefits, CMS Star ratings, and CalOptima Health's completion of the National Committee for Quality Assurance Health Equity Accreditation Initial Survey.

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

3. Chief Financial Officer (CFO) Report

Nancy Huang, CFO, started by reporting that she will bring a high-level financial update to the full Board on quarterly basis, as recommended at the last Finance and Audit Committee. Ms. Huang shared notable events for September, which included $212.1 million of hospital Directed Payments (DP) paid out in September 2025 for Calendar Year (CY) 2023 and $9.1 million of Quality Incentive Pool Program (QIP) paid out in September 2025 for CY 2024.

Mr. Huang reviewed the September 2025 financial details with the Board and responded to Board members' comments and questions.

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ADVISORY COMMITTEE UPDATES

4. Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) Updates

Christine Tolbert, MAC Chair, provided an update on the recent activities of the MAC and PAC, which included in-depth presentations from Dr. Dabbah and Dr. Rose, a budget update from Nancy Huang, and a verbal legislative summary from Donovan Higbee. Ms. Tolbert reported that the PAC welcomed a new member, Dr. Megerian. She noted that the written report provides further detail but wanted to express appreciation for the depth of information shared and the high level of engagement from committee members.

Looking ahead, the December agenda is expected to include a behavioral health update with a potential joint presentation from CalOptima Health and the County of Orange. She also noted that MAC and PAC anticipate a CalAIM update, which may include information on subsidized housing, and a formal legislative update.

Additionally, she added that the MAC will be voting on a recommendation to appoint a dental provider, a local education agency representative, and a Medi-Cal beneficiary to the committee. Ms. Tolbert noted that these appointments are in alignment with the updated All Plan Letter from DHCS, which restructured the committee's composition (as approved at the last Board meeting).

Mr. Hunn thanked Ms. Tolbert and the members of the MAC and PAC. He noted that MAC/PAC meetings are really turning into very robust meetings, with lots of detail and input. Mr. Hunn added that CalOptima Health is getting a lot of feedback from the members on both committees. He thanked Ms. Tolbert and shared that one of the commitments CalOptima Health made early on was to start including the two committees early in any process looking at the systems, structures, and policy implementation. Mr. Hunn asked Ms. Tolbert if she feels that CalOptima Health is fulfilling that commitment.

Ms. Tolbert responded robustly yes, noting the increased collaboration is truly refreshing. While she has mentioned this before, it is worth emphasizing how much the MAC and PAC value the integration of both committees' perspectives. This approach not only enhances the service to the community but also ensures that committee members are informed early about upcoming initiatives. Having that insight in advance allows the committee members to contribute meaningfully, bringing forward helpful information and feedback before decisions are finalized. Ms. Tolbert added that this has been a thoughtful and intentional effort, and it is making a real difference.

Ms. Tolbert thanked staff for the flexibility and responsiveness shown in adapting to new committee member needs. These shifts have been handled with agility, and it has been noticed and appreciated by both MAC and PAC members. The committee members truly feel the increased collaboration and feel that their input is valued.

PUBLIC COMMENTS

- Mark Lowry, Community Action Partnership of Orange County: Oral report regarding Agenda Item 13.
- Claudia Keller, Second Harvest Food Bank of Orange County: Oral report regarding Agenda Item 13.

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CONSENT CALENDAR

5. Minutes
   a. Approve Minutes of the October 2, 2025, Regular Meeting of the CalOptima Health Board of Directors
   b. Approve Minutes of the October 16, 2025, Special Meeting of the CalOptima Health Board of Directors
   c. Receive and File Minutes of the June 18, 2025, Special Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

6. Approve Modifications to CalOptima Health Quality Improvement Policies

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

8. Ratify Amendments to CalOptima Health's Primary Agreement and Secondary Agreement with the California Department of Health Care Services

9. Authorize Amendments to the CalOptima Health Contracts with Edifecs Inc. for Covered California Related Services and Enterprise Data Management Software and the Consolidation of the Contracts

10. Approve New CalOptima Health Policy CC.1502: Coverage for Rape and Sexual Assault Treatment Services

11. Approve Actions Related to Covered California Administrative Services Agreement for Transportation

12. Receive and File:
   a. September 2025 Financial Summary
   b. Compliance Report
   c. Government Affairs Reports
   d. CalOptima Health Community Outreach and Program Summary
   e. Fiscal Year 2025 Strategic Plan Performance Executive Status Report June-September 2025
   f. Member Grievances and Appeals Reports

Action: ***On motion of Director Byron, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 5 through 12, as presented. (Motion carried 9-0-0)***

REPORTS/DISCUSSION ITEMS

13. Approve Actions Related to Federal Shutdown Response Supplemental Food Support for CalOptima Health Members

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

Supervisor Chaffee thanked staff for bringing this important action before the Board; however, he questioned whether the $2 million dollar allocation is adequate. Supervisor Chaffee added that as

CalOptima Health's community partners reported during their public comments, this Board action is only 1.6% of their budget, meaning 98.4% of the need remain unmet.

The Board also requested that the food banks distribute the funds where the need is greater looking at the overall population in Orange County. After considerable discussion, the Board took the following amended motion:

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Appropriated and allocated up to ~~$7.0~~ $8million from existing reserves to fund supplemental food support for Medi-Cal members during the federal shutdown as follows: a.) Up to ~~$2.0~~ $3 million to fund grant agreements with two Orange County food bank distribution hubs; and b.) Up to $5.0 million to provide one $25 nonmonetary flex card to individual Medi-Cal members who are enrolled in the Supplemental Nutrition Assistance Program; 2.) Authorized the Chief Executive Officer or designee to execute and administer grant agreements and release award payments up to ~~$1.0~~ $1.5 million each to Second Harvest Food Bank of Orange County and Community Action Partnership Orange County; 3. Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose; 4.) Authorized CalOptima Health staff to work with the Social Services Agency of Orange County to determine a list of CalOptima Health members who are also receiving Supplemental Nutrition Assistance Program benefits, who will be eligible for a $25 nonmonetary flex card from CalOptima Health as additional food support while these benefits are suspended; and 5.) Authorized the Chief Executive Officer or designee to execute a contract amendment with Soda Health, the flex card vendor, to update the scope of work and payment terms for the administration and distribution of flex cards to Medi-Cal members eligible to receive the supplemental food support. (Motion carried 9-0-0)***

Rev. 11/6/25

14. Adopt Resolution No. 25-1106-01 Approving the Revised 2026 CalOptima Health Compliance Plan, 2026 CalOptima Health Code of Conduct, 2026 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan, 2026 CalOptima Health HIPAA Privacy and Security Program, and Revised CalOptima Health Office of Compliance Policies and Procedures

Vice Chair Sarmiento complimented staff on the revised Code of Conduct. He was happy to see many suggestions incorporated into the document. He did ask for more background on the First Tier Downstream (FDR) definition.

John Tanner, Chief Compliance Officer, responded that while the definition can vary slightly over time and between regulatory bodies, generally speaking a first-tier entity refers to any organization with which CalOptima Health has a direct contract to provide healthcare or administrative services required under its agreements with DHCS or CMS. A downstream entity is any party that contracts with a first-tier entity to provide those same services and may include additional layers of subcontracting beyond that. A related entity typically refers to an organization that is affiliated through ownership or control.

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Mr. Tanner noted that the latter are more common in large, complex, or commercial organizations. Currently, CalOptima Health does not have any related entities. These definitions are important for compliance and oversight purposes, particularly in the context of regulatory reporting and contractual obligations.

Vice Chair Sarmiento noted that what caught his attention was the sanctions section of the policy that the Board will be approving. He noted that it says sanctions imposed may include but not limited to termination of the contract between the health network or FDR and CalOptima Health. Vice Chair Sarmiento would like the language to be changed to have the Board in its authority, review and decide the outcomes of the serious allegations that would sanction or terminate a health network or FDR.

Mr. Hunn suggested that the Board approve this action today and have staff bring an action back to the Board for consideration. He noted that, because this overall compliance plan is a requirement of CalOptima Health's regulators and any changes will also affect CalOptima Health's contracts that also need regulator approval. CalOptima Health does not want to risk non-compliance by modifying language until CalOptima Health is able to notify both regulators and providers alike. Mr. Hunn committed to having staff bring back another action to address the Board's oversight with regard to sanctions and terminations.

Vice Chair Sarmiento thanked Mr. Hunn for the suggestion, and the Board approved the action below as presented.

Action: ***On motion of Vice Chair Sarmiento, seconded and carried, the Board of Directors: Adopted Resolution No. 25-1106-01 approving: a.) Revised 2026 CalOptima Health Compliance Plan; 2026 CalOptima Health Code of Conduct; 2026 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan; and the 2026 CalOptima Health HIPAA Privacy and Security Program; and b.) Revised CalOptima Health Office of Compliance policies and procedures. (Motion carried 9-0-0)***

15. Authorize Amendments to the CalOptima Health Behavioral Health Professional Services Contracts for the Medi-Cal Program

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

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer, or designee, to negotiate and execute amendments to the CalOptima Health behavioral health Professional Services Contracts for therapeutic repetitive transcranial magnetic stimulation services for the Medi-Cal program, effective on or after December 1, 2025; and 2.) Authorized reimbursement for covered therapeutic repetitive transcranial magnetic stimulation services at the lesser of billed charges or 100% of local Medicare fee schedule rates for dates of service on and after July 1, 2024. (Motion carried 7-0-0; Chair Becerra and Director Mayorga recused)***

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16. Consider a Request to Support a Proposed Amendment to CalOptima Health's Governing Ordinance
This item was continued to the December Board meeting.

CLOSED SESSION
The Board adjourned to Closed Session at 3:34 p.m. Pursuant to Government Code section 54956.87, subdivision (b) HEALTH PLAN TRADE SECRETS: Covered California; CONFERENCE WITH LEGAL COUNSEL – Anticipated Litigation, pursuant to Government Code Section 54956.9 (d)(2), (e)(1): 2 cases; and CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION: Significant exposure to litigation pursuant to Government Code section 54956.9(d)(2) and (e)(1): up to 2 potential cases.

The Board returned to Open Session at 5:46 p.m., and the Clerk re-established a quorum.

ROLL CALL

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

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

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS
Director Mayorga thanked staff and his fellow Board members for their commitment and collaboration in advancing the concept that food is medicine. While CalOptima Health's contribution may have been modest, he believes it was a meaningful step in the right direction for its community. Director Mayorga added that he hopes that others with the capacity to do so will be inspired to join CalOptima Health in this important effort.

ADJOURNMENT
Hearing no further business, Chair Becerra adjourned the meeting at 5:48 p.m.

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Sharon Dwiers
Clerk of the Board

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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 18, 2025

A Regular Meeting of the CalOptima Health Board of Directors' (Board) Finance and Audit Committee (FAC) was held on September 18, 2025, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under Past Meeting Materials.

Chair Isabel Becerra called the meeting to order at 3:02 p.m., and Director Blair Contratto led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair; Blair Contratto; Brian Helleland (all members participated in person)

Members Absent: None.

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

MANAGEMENT REPORTS

1. Chief Financial Officer (CFO) Report

Nancy Huang, CFO, provided two updates for the CFO Report.

The first update was regarding rate updates for Calendar Years (CYs) 2025 and 2026. Ms. Huang noted that staff continue to monitor the implementation of Proposition 35, which was approved by voters last November. This measure outlines how the Department of Health Care Services (DHCS) can utilize Managed Care Organization (MCO) tax revenue. With recent federal legislation allowing revised provider taxes, CalOptima Health anticipates further guidance from DHCS regarding Phase II of the targeted provider rate increases. These changes may affect both service categories and funding levels. As of now, DHCS has not released additional details. Staff will continue to monitor and report back as updates become available.

Looking ahead to CY 2026, DHCS has shared a draft rate release timeline. Draft rates are expected by the end of September, with feedback due by October 9. Final prospective rates will be issued in early November. Staff will track developments and provide fiscal impact updates at future meetings.

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The second update concerns the implementation of CalOptima Health's new cloud-based Enterprise Resource Planning system, part of the broader digital transformation strategy. Ms. Huang noted that CalOptima Health, following a request for proposal process, selected Microsoft Dynamics 365 to replace multiple legacy systems, including accounting, requisitions, travel and training authorizations, and expense reporting. This integrated platform will streamline workflows, enhance interdepartmental efficiency, and improve data reporting capabilities. Ms. Huang added that CalOptima Health is on track for a go-live date of November 1, 2025.

2. Cybersecurity Update

James Steele, Senior Director, Information Security, presented an update on CalOptima Health's cybersecurity. He noted that this quarter, CalOptima Health experienced zero major cybersecurity incidents. Mr. Steele also noted that CalOptima Health had one notable but non-reportable incident which was discussed in detail at the last meeting, regarding a compromised device. There was no impact to CalOptima Health systems or data. Mr. Steele also reported that CalOptima Health tracked three notable third party cybersecurity incidents this quarter: (1) the DaVita ransomware attack, which occurred in late Quarter 2, and was included in the materials for the previous FAC meeting; (2) a ransomware attack that affected one of CalOptima Health's vendors, EpiSource; and (3) two business email compromise (BEC) incidents experienced by a partner organization. The second BEC incident occurred after the first incident was believed to be resolved, highlighting the persistence of the threat.

Mr. Steele reviewed the latest cybersecurity news, which included the DaVita ransomware incident as it remains a key case study. While DaVita maintained operations through the breach, reports indicate the breach was preventable. This underscores the importance of a proactive, risk-based security program —not one driven solely by compliance. CalOptima Health continues to prioritize security as a strategic function focused on protecting member data, not just meeting regulatory requirements. In addition, Mr. Steele reported that the Federal Bureau of Investigation Internet Crime Complaint Center issued an advisory highlighting a 43% increase in cybercrime targeting older adults since 2003. This reinforces the need for ongoing education and awareness, which CalOptima Health has integrated into its Board training efforts.

Mr. Steele reviewed the cybersecurity metrics for quarter three, which included (1) third-party incidents, that included previously discussed breaches of DaVita and EpiSource that occurred in quarter two but were reported in the metrics for continuity; (2) non-reportable incidents, which was the one internal device compromised but contained with no impact; and (3) data loss prevention, including four incidents involving misdirected emails that were addressed with corrective training. Mr. Steele also reviewed (i) email threats, noting that of over 4 million emails received last quarter, approximately 55% were flagged as malicious; (ii) web and app threats, noting that 52 phishing websites and 148 malicious applications were blocked; and (iii) asset protection, noting that as CalOptima Health modernizes its infrastructure, it continues to expand security controls across servers, workstations, and new systems, reflecting the growing scope of its cybersecurity efforts.

Mr. Steele and Ms. Kim 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, 2025, through June 30, 2025. The portfolio totaled approximately $3.4 billion. Of the total portfolio amount, $1.7 billion was in CalOptima Health's operating account, and approximately $1.7 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 $132 million set aside for tangible net equity (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.

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 22, 2025 Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee and Receive and File Minutes of the April 21, 2025, Regular Meeting of the CalOptima Health Board of Directors' Investment Advisory Committee

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

REPORTS/DISCUSSION ITEMS
5. Recommend Reappointment of the CalOptima Health Board of Directors' Investment Advisory Committee

Action: ***On motion of Director Helleland, seconded and carried, the committee recommended that the Board of Directors reappoint Rick Fulford to the Board of Directors' Investment Advisory Committee for a two (2)-year term beginning November 3, 2025. (Motion carried 3-0-0)***

6. Recommend that the Board of Directors Accept, Receive, and File the Fiscal Year 2024-25 CalOptima Health Audited Financial Statements
Ms. Huang introduced representatives from Baker Tilly, US LLP, formerly Moss Adams, LLP, (Baker Tilly) 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.

Aparna Venkateswaran, Audit Engagement Reviewer at Baker Tilly, presented the draft audit of the consolidated financial statements for the fiscal year ending June 30, 2025.

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 Baker Tilly will assist with filing the Single Audit for the Multipurpose Senior Services Program. However, the Office of Management and Budget has not yet released the 2025 compliance supplement, which is required before Baker Tilly can issue the Single Audit. While it will proceed with issuing the financial statement audit, the Single Audit will be delayed until the supplement is

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available. Ms. Venkateswaran indicated that Baker Tilly does not anticipate any changes to the program audit, and once the supplement is released, they will complete their review and issue the report.

Ms. Venkateswaran introduced Ashley Merda, Audit Senior Manager, who provided additional details on the audit.

Action: ***On motion of Director Helleland, seconded and carried, the committee recommended that the CalOptima Health Board of Directors accept, receive, and file the Fiscal Year 2024-25 CalOptima Health consolidated audited financial statements as submitted by independent auditors Baker Tilly US, LLP, previously Moss Adams LLP. (Motion carried 3-0-0)***

Chair Becerra asked for an overview of Information Item 10.a. Quarterly Report of the Net Asset Analysis

INFORMATION ITEMS

10. Quarterly Reports to the Finance and Audit Committee
    a. Net Asset Analysis

Ms. Huang provided an overview of CalOptima Health's Net Asset Analysis, noting that as of June 2025, CalOptima Health's total net assets are $2.8 billion, allocated across four primary categories:

(1) Board-Designated and TNE Reserves: The largest portion, approximately $1.7 billion (60%), is allocated to Tier 1 and Tier 2 reserves. Following a Board-approved policy change in April to increase the reserve cap from 3 times to 4 times of monthly revenue, $460 million was transferred to Tier 1 accounts. This raised the reserve level to 3.8 times monthly capitation revenue, exceeding the Department of Managed Health Care (DMHC) minimum requirements.

(2) Fixed Assets: About $99 million (3.5%) represents the net value of CalOptima's buildings, equipment, and improvements.

(3) Board-Approved Initiatives: $720 million (26%) remains unspent from previously approved initiatives, including a $526.2 million provider rate increase program (with $315 million still available), community outreach, quality incentive programs, and infrastructure investments.

(4) Unallocated Resources: $265 million (9.5%) is available for future Board-directed programs or initiatives, providing flexibility amid ongoing state and federal policy uncertainties.

Ms. Huang noted that CalOptima Health is spending about $12 million per day in total, and its reserves can support 168 days of operations inclusive of administrative and claims.

Director Contratto commented that as CalOptima Health anticipated, enrollment is gradually declining—approximately 14,000 members over the past year, with an additional 2,000 in July. This trend appears to be driven less by the quality of care and more by the current political climate and the uncertainty many individuals are facing. She requested that staff bring back to the committee the volume and dollar amount of claims being denied due to members losing eligibility – particularly those still being treated by providers who believe the patients are covered under CalOptima Health. Director Contratto noted that understanding this could help the Board better grasp the broader impact of eligibility changes and the rationale behind

transitioning members to the Exchange, even though some may not qualify. She added that CalOptima Health's providers are central to the strength of its health plan, and it is important to recognize the challenges they face. This may also inform future discussions around the use of reserves, such as whether to establish a foundation or charitable component to support these efforts.

Director Contratto also inquired about members who may lose eligibility but still visit a doctor the day before or after that change. She inquired whether providers, especially those directly contracted with CalOptima Health, are required to verify eligibility before every encounter; or whether some services are being rendered without real-time confirmation, potentially leading to denied claims after the fact.

Ms. Kim responded that CalOptima Health providers are required to check eligibility at the time of service. She added that CalOptima Health does deny claims when the claim is for a date of service where the member was not eligible on that date of service. Ms. Kim noted that it is the provider's responsibility to check to see if that patient is eligible. She noted that due to this fact it would be difficult to get a true picture of how many individuals are receiving care where the provider is not getting reimbursed, because the provider would not submit a claim. Ms. Kim noted that staff could pull the numbers to see how many claims are being denied.

Director Contratto requested more detailed financial information to be included in the CFO Report, including monthly or quarterly updates on expense control and administrative costs. She would also like to see additional context and supporting documentation for compensation changes, including executive compensation and market adjustments.

Ms. Huang responded that the Finance Department would work with Human Resources staff to provide more detailed information in future reports regarding compensation and market adjustments.

Director Contratto commented that CalOptima Health's CalAIM program is one of the top in the state with a significant number of members receiving services. She noted that the financial numbers are great; however, she would like to see a report that provides program goals and potential for improvement or celebration.

Director Helleland echoed Director Contratto's comments, emphasizing the need for an executive summary and a clear explanation of the program's goals and methods.

Ms. Kim proposed a discussion on the CalAIM program at the next meeting, focusing on the program's experience and future direction as it enters its final year.

Ms. Huang agreed with committee members and the need for a more detailed program update, including specific benefits, return on investment, and results at the individual level.

INFORMATION ITEMS
The following items were accepted as presented.

7. July 2025 Financial Summary

8. Quarterly Operating and Capital Budget Update

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9. CalAIM Program Summary

10. Quarterly Reports to the Finance and Audit Committee
    a. Net Asset Analysis (This item was discussed at the top of the Information Items.)
    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 4:32 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: November 20, 2025

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2025
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 5, 2024, meeting, the Board approved changes to CalOptima Health Policy GA.3400: Annual Investments for Calendar Year (CY) 2025. The policy was revised to clarify 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 and to remove these institutions as eligible investments, as investment managers investing on behalf of local agencies cannot make investments in these entities directly.

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 2026. 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.a.iv	Add "Financial futures contracts related to U.S. government securities are permitted for the sole purpose of managing the portfolio duration within the Tier One or Tier Two	Adds Treasury futures as a permitted investment tool to the portfolio.	Permits the purchase of a new investment tool, Treasury futures. Investment guidelines are established in Section III.E.7 to mitigate the

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Policy Section	Proposed Change	Rationale	Impact
	portfolios. Contracts are subject to the Maximum Term Assigned."		inherent risk of Treasury futures.
III.D.2.l.ii	Remove "London Interbank Offered Rate (LIBOR)"	Removes reference to LIBOR from variable and floating rate securities as it was discontinued as of June 30, 2023.	None.
Section III.E.3	Add "(including U.S. Agency Mortgage Backed Securities and Asset Backed Securities)"	Clarifies U.S. Agency Mortgage Backed Securities and Asset Backed Securities fall under the Federal Agencies and U.S. Government Sponsored Enterprises investment type, which is subject to a maximum 100% of the portfolio at the time of purchase.	None.
Section III.E.7	Add: "7. Financial Futures Contracts Guidelines: a. Limited to U.S. Government Securities for the purpose of hedging duration risk in Tier One and Tier Two portfolios; b. Subject to a maximum 20% gross notional value of total portfolio at time of purchase; and c. Have a maximum Contribution to Duration of +/- 0.35 years."	Adds specific guidelines investment managers must adhere to when using financial futures contracts in Tier One and Tier Two portfolios.	None.
Section IX	Add definition for "Contribution to Duration" and "Gross Notional Value"	Defines new terms introduced in the policy that applies to financial futures contract guidelines.	None.

Financial Futures Contracts Related to U.S. Government Securities

Permitting financial futures contracts related to U.S. government securities complies with the California Government Code requirements. It provides investment managers with a flexible and efficient tool to manage interest risks and portfolio durations.

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The recommended policy changes include additional guidelines for the use of financial futures contracts, including limiting them to U.S. government securities only, capping them at 20% of the total portfolio at the time of purchase, and implementing a maximum contribution to the duration of +/- 0.35 years. These controls are designed to mitigate the inherent risks associated with futures and ensure their prudent use within the portfolio.

Fiscal Impact
There is no immediate fiscal impact.

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 *11/25/2025*
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:	**01/01/2026**
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20251204 BOD Review Only

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

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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.

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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

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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. Financial futures contracts related to U.S. government securities are permitted for the sole purpose of managing the portfolio duration within the Tier One (1) or Tier Two (2) portfolios. Contracts subject to the Maximum Term Assigned.

~~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

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;

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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:

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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
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:

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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 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

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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 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

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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

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Fund Type	Term Assigned	Term Allowed by the Code
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

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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 (including U.S. Agency Mortgage Backed Securities and Asset Backed Securities)	100% (Code)
C. State and California Local Agency Obligations	40% (Code 100%)
D. Bankers Acceptances	30% (Code 40%)

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INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
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. Non-Agency 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

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

[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.

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7. Financial Futures Contracts Guidelines:

a. Limited to U.S. Government Securities for the purpose of hedging duration risk in Tier One (1) and Tier Two (2) portfolios;

b. Subject to a maximum twenty percent (20%) gross notional value of total portfolio at time of purchase; and

c. Have a maximum Contribution to Duration of +/- 0.35 years.

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 forty-five (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~~,~~ in Section III.D.2.a.iv., 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

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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

For 12/5/2024 BOD Review Only

Date	Meeting
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors
12/04/2025	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
Revised	01/01/2026	GA.3400	Annual Investments	Administrative

For 20251204 BOD Review Only

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.
Contribution to Duration	Contribution to duration (CTD) refers to how much a specific holding (such as financial futures contracts) impacts the overall interest rate risk of a portfolio.
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.

For 2025 12/04 BOD Review Only

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.
Gross Notional Value	The total underlying asset value of a financial contract or position.
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.

For 2025 2nd BoD Review Only

Term	Definition
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)
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.

For 2025 12/4 BOD Review Only

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.

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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:	01/01/2026
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20251204 BOD Review Only

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

For 20251204 BOD Review Only

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.

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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

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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. Financial futures contracts related to U.S. government securities are permitted for the sole purpose of managing the portfolio duration within the Tier One (1) or Tier Two (2) portfolios. Contracts subject to the Maximum Term Assigned.

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

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;

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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:

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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
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:

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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 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

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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 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

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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

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Fund Type	Term Assigned	Term Allowed by the Code
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, 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

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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 (including U.S. Agency Mortgage Backed Securities and Asset Backed Securities)	100% (Code)
C. State and California Local Agency Obligations	40% (Code 100%)
D. Bankers Acceptances	30% (Code 40%)

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INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
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. Non-Agency 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

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

[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.

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7. Financial Futures Contracts Guidelines:

   a. Limited to U.S. Government Securities for the purpose of hedging duration risk in Tier One (1) and Tier Two (2) portfolios;

   b. Subject to a maximum twenty percent (20%) gross notional value of total portfolio at time of purchase; and

   c. Have a maximum Contribution to Duration of +/- 0.35 years.

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 forty-five (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 in Section III.D.2.a.iv., 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

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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

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Date	Meeting
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors
12/04/2025	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
Revised	01/01/2026	GA.3400	Annual Investments	Administrative

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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.
Contribution to Duration	Contribution to duration (CTD) refers to how much a specific holding (such as financial futures contracts) impacts the overall interest rate risk of a portfolio.
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.

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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.
Gross Notional Value	The total underlying asset value of a financial contract or position.
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.

For 2025 2nd BoD Review Only

Term	Definition
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)
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.

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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.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 4, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Approve the New CalOptima Health Policy GA.8064

Contacts

Steve Eckberg, Chief Human Resources Officer, (657) 328-9053
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions

Approve the new CalOptima Health Policy GA.8064: Deferred Compensation Investments, that will apply to all deferred compensation plans and replace the existing Investment Policy Statement.

Background

Section 457(b) Deferred Compensation Plan

On December 20, 1994, the CalOptima Health Board of Directors (Board) approved the establishment of a deferred compensation program (Program) for employees under Section 457(b) of the Internal Revenue Code, including a deferred compensation plan (Plan). Since then, on several occasions, staff brought recommended changes to the Program to the Finance and Audit Committee (FAC) and the Board for their respective approvals.

At the March 4, 2021, meeting, the Board approved the Investment Policy Statement for the 457(b) Compensation Plan (Statement). This Statement was developed by the CalOptima Health Deferred Compensation Committee and CalOptima Health's independent investment advisor, SageView Advisory Group, LLC, to establish policies and guidelines for the Plan, define investment management procedures, and ensure a prudent and acceptable investment philosophy. The Board delegated authority to the Committee to interpret the Plan and adopt rules and regulations for the administration of the Plan, provided they are not inconsistent with the Plan and comply with Section 457(b) of the Internal Revenue Code and any applicable regulations. Staff would return to the FAC and the Board with any substantive revisions to the Statement for review and approval.

Section 401(a) Defined Contribution Plan

On January 5, 1999, the Board approved the establishment of a Supplemental Retirement Plan (SRP) for CalOptima Health employees and established an SRP Committee. CalOptima Health contracted with the Public Agency Retirement Services in 1999 to implement and administer the SRP, a 401(a) tax-qualified multiple employer trust. The SRP is funded by an employer contribution of four percent (4%) of employee base earnings.

On June 6, 2024, the Board authorized staff to develop a scope of work and release a request for proposals for an SRP administrator. CalOptima Health selected Empower Retirement LLC as the successor SRP administrator for CalOptima Health's SRP 401(a) with a transition date of January 2, 2025.

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Discussion
Staff recommends modifying the existing Investment Policy Statement by placing the statement into CalOptima Health's policy template and adding the 401(a) Defined Contribution Plan to the policy. This ensures that CalOptima Health's fiduciary duties are clearly defined and consistently applied across the Plan and the SRP.

To improve transparency and track modifications to the Investment Policy Statement, staff incorporated the Investment Policy Statement from a stand-alone document into an internal CalOptima Health policy and completed the internal administrative policy review process. CalOptima Health Policy GA.8064: Deferred Compensation Investments will replace the standalone Investment Policy Statement upon approval. Staff will make future changes related to the Investment Policy Statement by recommending revisions to CalOptima Health Policy GA.8064 to the FAC for review and to the Board for approval.

In addition to this substantive change, staff made other non-substantive edits that were noted during the review process, as well as other formatting revisions intended to align the Investment Policy Statement with CalOptima Health's policy and procedure template.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2025-26 Operating Budget approved by the Board on June 5, 2025.

Rationale for Recommendation
Approval of new CalOptima Health Policy GA.8064, which replaces the Investment Policy Statement and includes all retirement plans, will update the policies and guidelines for the administration of the Plan and SRP and improve transparency and tracking of future changes.

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

Attachments
1. New CalOptima Health Policy GA.8064: Deferred Compensation Investments
2. Previous Board Action March 4, 2021, "Consider Adoption of Investment Policy Statement for CalOptima's 457(b) Deferred Compensation Plan"

/s/ Michael Hunn *11/25/2025*
Authorized Signature **Date**

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Policy:	GA.8064
Title:	**Deferred Compensation Investments**
Department:	Human Resources
Section:	Not applicable
CEO Approval:	
Effective Date:	01/01/2026
Revised Date:	Not Applicable
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This Policy establishes the guidelines for CalOptima Health's deferred compensation investments including the 457(b) Deferred Compensation Plan and the 401(a) Defined Contribution Plan (collectively, the "Plans"). These guidelines assist the CalOptima Health Deferred Compensation Committee (the "Committee") in developing a prudent and acceptable investment philosophy with investment management procedures to effectively select, monitor and evaluate investment alternatives made available to employees.

II. POLICY

A. The Plans were established to provide a retirement savings program for eligible employees of CalOptima Health. They are maintained for the exclusive purpose of benefiting employees and their beneficiaries. The Plans will operate in accordance with applicable state and federal laws and regulations.

The Plans are intended to provide a framework for eligible employees to establish a savings and investment program for their retirement (457(b) Deferred Compensation Plan) and to supplement retirement benefits provided under the California Public Employee Retirement System (CalPERS) (401(a) Defined Contribution Plan). While employees are ultimately responsible for their own investment decisions, CalOptima Health, in conjunction with our investment consultant, will provide under each Plan an appropriate range of investment alternatives, allowing each individual employee to invest in accordance with his or her own time horizons, risk tolerance, and retirement goals. In evaluating the investment alternatives for the Plans, CalOptima Health will take into account all Plan demographics.

1. Investment objectives for the Plans include:

   a. Providing employees with a wide and suitable range of asset categories and investment alternatives that are intended to help employees meet their retirement goals and investment objectives; and

   b. Obtaining Plan investment alternatives at reasonable costs and controlling overall investment related service costs.

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2. Benefits objectives for the Plans include:

    a. Promoting retirement savings while encouraging employee participation as a vehicle to accumulate assets to provide for a portion of their retirement needs; and

    b. Attracting and retaining outstanding employees by providing diverse investment options.

3. Specific objectives for this policy include:

    a. Establishing investment objectives and standards for the investment options offered to assure that the Plans' assets are managed in accordance with the investment policy;

    b. Establishing formal criteria and process to evaluate investment performance results;

    c. Providing a formal process for reviewing and modifying the investment policy; and

    d. Satisfying the fiduciary responsibilities of the Deferred Compensation Plan Committee and its Members.

B. Statement of Responsibilities: The following parties associated with the Plans, appointed by CalOptima Health, shall discharge their respective responsibilities in accordance with applicable fiduciary standards. All Plan fiduciaries shall complete education and ethics training that covers aspects of their duties and responsibilities as fiduciaries of the Plans, including, but not limited to, best practices, plan compliance, legislative and regulatory activities, as well as investment alternative selection, monitoring and replacement.

1. Deferred Compensation Committee: The Deferred Compensation Committee oversees the investment of plan assets, adhering to best practices such as the Duty of Loyalty and Duty of Prudence. While responsible for investment selection, the Committee does not guarantee individual fund performance and may engage a qualified investment consultant for assistance.
2. Trustee: The Trustee of the Plans is charged with safekeeping the securities as well as collecting and disbursing the Plan assets and periodic accounting statements.

3. Recordkeeper: The Recordkeeper has responsibilities that include, but are not limited to, the following: maintaining employee records, administering employee directions, reporting to the CalOptima Health, reporting to employees, allocating contributions, administering loans, and preparing the required regulatory documents.

4. Investment Consultant: If CalOptima Health elects to use an investment consultant, the investment consultant is charged with the responsibility of advising the Committee on investment policy, advising on the selection of investment alternatives, providing performance analysis and monitoring services, and educating the Committee on economic and investment trends that may impact the performance of the selected and available investment alternatives. The investment consultant shall evaluate changes in legislation and regulations to ensure compliance regarding investment matters.

C. Investment Choices: The Plans intend to provide a broad range of investment alternatives. This includes having, at a minimum, three (3) diversified investment alternatives that are sufficient to permit employees to materially affect the potential return and degree of risk on their accounts, and to minimize the risk of large losses. Diversification, however, does not ensure a profit or protect against loss in a declining market.

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All investment choices will be publicly available mutual funds, institutional trusts, or similar vehicles. All investments being offered will fluctuate in value with market conditions and, when redeemed, may be worth more or less than the amount originally invested. The chosen investment alternatives were selected on the basis of their compatibility with employees' needs and regulatory recommendations. Each of the chosen investment alternatives is designed to follow a specific stated investment objective.

1. Qualified Default Investment Alternative (QDIA)

    a. Although the Committee intends that employees will direct the investment of their assets held under the Plans, there may be circumstances (particularly for the 401(a) Defined Contribution Plan, which does not require an active enrollment process) under which employees do not provide direction regarding the investment of their individual accounts. In such instances, employee accounts will be invested in the Plans' default investment alternative. The Committee's intention is for the Plans to comply with the Pension Protection Act of 2006 by offering a default investment alternative that complies with the conditions required of a QDIA investment alternative.

    b. The Committee may elect to utilize a multi-asset class investment alternative, such as target-date funds, as the QDIA. Periodically, as employee demographics or market conditions require, the Committee review and document the process for monitoring and selecting the QDIA, considering such factors as the philosophy and goals of the Plan Sponsor as well as the needs and abilities of the employees and beneficiaries.

    c. The specific target date portfolio for an employee or beneficiary who fails to make an investment election will be based on the employee's or beneficiary's date of birth and an assumed normal retirement date of age sixty-five (65).

D. Selection of Investment Alternatives: The Plans will take a two-tiered approach to investment alternative selection. Quantitative and qualitative screens are used as follows:

1. Quantitative Screening (including but not limited to):

    a. Investment track record

    b. Investment risk

    c. Investment risk/return

    d. Investment style analysis

    e. Performance consistency

    f. Investment cost

    g. Turnover ratio

2. Qualitative Screening (Investments that pass the quantitative screens will be reviewed for characteristics that include but are not limited to):

    a. Investment-style variations

    b. Portfolio concentration

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c. Asset size and growth

3. Interviews with portfolio managers and/or analysts will also be conducted if deemed necessary.

a. Selected alternatives will be reviewed to ensure that there are no additional factors that would make them unsuitable for inclusion in the Plans. Each alternative will also be examined to ensure that it appropriately complements the overall diversification and risk and return parameters of the entire Plan investment lineup.

b. In addition to diversification and risk tolerance considerations, investment expenses will be considered in the selection of investment alternatives. The Committee will regularly review all costs associated with the management of the Plans' investment program. These costs include the following:

i. Expense ratios of each investment alternative against the appropriate peer group;

ii. Trustee and custodial fees for holding assets, collecting income and paying disbursements; and

iii. Plan administrative fees, including record keeping fees and other fees associated with services the Plan receives, such as compliance testing fees, audit fees, fees for communication services, etc.

III. PROCEDURE

A. Evaluation Methodology: The Committee will use the following criteria in selecting and monitoring Plan investment alternatives. Each Plan investment alternative will be evaluated on an ongoing basis using several measures that quantify the expenses, returns and risk-adjusted performance of each investment alternative within its peer group.

1. Each Plan investment alternative will be reviewed at least annually against its peer group and benchmark index to assess the performance and quality of each offering. The list of criteria that may be used for evaluation is included as Attachment B of this document and may be updated by the Committee, as necessary.

2. As noted in Attachment A, whenever possible, each investment alternative is benchmarked to a specific market index, and performance is evaluated and compared to a relevant peer group using Morningstar category classifications. Each criterion for an investment alternative is given a peer group ranking, shown as a percentage. As an example, a criterion ranking of 10% indicates an investment alternative is in the top 10% of its peer group for said criterion. The rankings for all criteria are then weighted and averaged to give an investment alternative its average ranking score. The lower the average ranking score, the better. In general, an investment alternative with an average ranking score of 25% would be more attractive than a comparable investment alternative with a ranking score of 50%. An overall ranking score is used to indicate where an investment alternative places in relation to the scores of the other investment alternatives in its category. Generally, investment alternatives are divided into categories of deciles and quartiles.

3. Peer group rankings require a three (3)-year history to ensure an accurate evaluation of the investment alternative. Any investment alternative with fewer than three (3) years of history will not be evaluated using this method. In the event there is a sufficiently similar investment

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alternative, the Committee may elect to use its history for evaluation purposes. Sufficiently similar investment alternatives may include:

a. Alternate share classes of the same product.

b. Other products, such as collective investment trusts (CITs), separate accounts or recordkeeper sub-advised investment alternatives, that are managed by the same portfolio management team according to a substantially similar investment strategy.

4. In addition to the quantitative methodology described above, many qualitative criteria and possible warning signs are monitored in order to highlight an investment alternative's potential exposure to risk that may make it unsuitable as a retirement Plan investment option. The warning signs may include (but are not limited to):

a. Above-average operating expenses

b. Above-average style drift (as determined by returns-based and holdings-based analyses)

c. High degrees of portfolio concentration among individual holdings

d. High degrees of portfolio concentration among economic sectors

e. Above-average performance volatility

f. Above-average portfolio turnover

g. Below-average Alpha

h. Below-average manager tenure and/or above-average turnover

i. Rapid growth in assets

j. Significantly positive or negative cash flows

k. Unusual levels of corporate scrutiny; poor public perception

l. For bond portfolios, very low average credit quality relative to peers

m. For bond portfolios, significantly above- or below-average portfolio durations

n. Recent changes to or concerns with the firm structure / ownership

o. Recent changes to or concerns with the corporate management team structure

B. Other Investment Evaluation Criteria: The Committee recognizes that certain investment alternatives present challenges in monitoring, given the nature of the investment alternative's portfolio and peer group. Thus, there are several instances where investment alternatives will not fit neatly into the monitoring framework set forth herein. Therefore, the Committee will consider additional or different factors when evaluating certain investments. The following are common examples of investments requiring a different point of view, whether the Committee has included them in the current menu or may consider doing so in the future.

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One investment characteristic of these products is their investment in various sectors of the bond market. Thus, part of the evaluation will hinge on the evaluation of the underlying bond portfolio. The other important characteristic is financial credit worthiness of the insurance companies that issue wrap contracts to protect the book value of the bond portfolios. Some additional unique (albeit not exhaustive) metrics and characteristics that warrant evaluation include market-to-book value ratio, employee /plan sponsor withdrawal restrictions, crediting rate and wrap structure. For insurance general accounts, the Committee should at a minimum review the crediting rate, withdrawal restrictions, and credit worthiness ratings of the insurer.

1. Multi-asset class investments: For multi-asset class investment alternatives, such as target-date funds, the asset allocation and glide path should be evaluated taking into account factors such as generally accepted investment theories and prevailing investment industry practices, and goals of the plan, the philosophy of the fiduciaries regarding asset class diversification and the desired relationship of risk (or volatility) and potential return, and the needs and abilities of the employees and beneficiaries. The Committee, with the assistance of the investment consultant, expects to engage in a process to identify and consider those goals, preferences, needs and abilities and to select a default investment consistent with that analysis.

    a. As the process for comparing multi-asset class investments, including target-date funds, differs from the process used for other investment selections in several respects. Criteria listed elsewhere in this policy may not apply.

2. Index fund: The goal of an index fund is to closely mirror the performance of a predetermined index at a reasonable cost. The criteria which may be used to evaluate index funds is set forth in Appendix C and may be updated from time-to-time at the Committee's discretion.

    a. Each index fund will be compared to a standard index for its respective category classification and assigned a ranking in each of the four criteria. The rankings for all criteria are then weighted and averaged to give an investment alternative its average ranking score. Index funds with an average ranking score in the top 75% of the investment alternatives in a category are given a passing score ("Pass"), while investment alternatives below in the lowest 25% of investment alternatives are given a failing score ("Fail").

3. Stable value investments: The goal of a stable value fund is to preserve capital. Stable value investments come in several structures: pooled/commingled funds, insurance separate accounts, and guaranteed investment contracts (GICs)/insurance general accounts or derivatives thereof.

C. Monitoring of Investment Policy and Investment Performance: The Committee, with the assistance of the investment consultant, will review the Plans' Investment Policy and monitor each investment alternative on an ongoing basis. The Committee will periodically evaluate the investment results of the investment alternatives.

1. In addition, the Committee shall maintain a "Watch List" for investment alternatives that are not meeting certain objectives. An investment alternative will be placed on the "Watch List" will be placed on the Watch List if it meets either at least two of the conditions "a" through "g" below or condition "h":
    a. Performance below 50% of its peer group for a three (3)-year period

    b. Performance below 50% of its peer group for a five (5)-year period

    c. Performance below 50% of its peer group for a ten (10)-year period

    d. Performance below its benchmarks for a three (3)-year period

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e. Performance below its benchmarks for a five (5)-year period

f. Performance below its benchmarks for a ten (10)-year period

g. A Morningstar rating of two (2) or below

h. Extenuating circumstances, such as:

i. Change in fees

ii. Change of portfolio manager

iii. Change of sub-advisor

iv. Violations of SEC rules or regulations

v. Performance will be considered over a minimum of a three-year period and a maximum of a ten-year period unless a shorter-term underperformance is so severe that it warrants the Committee's immediate consideration for removal.

2. Investment alternatives that fail to meet qualitative criteria (i.e.: manager changes, fund company reorganizations, strategy changes) will be put on the Watch List by the Committee.

3. To be in good standing and removed from the Watch List, an investment alternative must not have more than one of the Watch List criteria "a" through "g" above. However, an investment alternative may have extenuating circumstances that warrants continuation on the Watch List.

4. The Committee shall have the authority to establish, modify, amend, or adjust acceptable performance measurement standards by which each investment alternative is to be evaluated.

5. Final selection, replacement and/or removal of an investment alternative shall be completed only after conducting a thorough review of the identified investment alternative.

6. An investment alternative on the Watch List will be removed from employee investment options if it is determined that extenuating circumstances are not in accordance with prudent investment standards or when conditions "a" through "e" below apply:

a. Performance below 50% of its peer group for a five (5)-year period

b. Performance below 50% of its peer group for a ten (10)-year period

c. Performance below its benchmarks for a five (5)-year period

d. Performance below its benchmarks for a ten (10)-year period

e. A Morningstar rating of two (2) or below

f. Extenuating circumstances, such as:

i. Change in fees

ii. Change of portfolio manager

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iii. Change of sub-advisor

iv. Any violations of SEC rules or regulations

v. Performance will be considered over a minimum of a three (3)-year period and a maximum of a ten (10)-year period unless a shorter-term underperformance is so severe that it warrants the Committee's immediate consideration for removal.

7. The Committee has discretion to retain any investment alternative if it remains a prudent option.

8. The Recordkeeper will communicate to all eligible employees the investment alternative(s) subject to removal.

9. After an investment alternative is removed, all existing balances and future contributions will be moved from the removed investment alternative to a similar existing investment alternative or a replacement fund. No new contributions or transfers will be accepted into a removed investment alternative.

10. The Plans will provide for regular communication of investment and Plan information in addition to necessary updates to inform employees of changes to the Plans. The Plans will not be responsible for providing investment advice to employees.

D. Proxy Voting: Should the Committee elect to participate in a proxy vote, the Committee will provide a detailed analysis of voting activities on an annual basis (calendar year). When voting proxies, the Committee will vote to the best of their abilities in the best interest of the participating employees. The Committee is not required to participate in all proxy votes related to the investments in the Plan. The investment consultant is able to offer general guidance and provide clarification with respect to the process of voting by proxy but will not be responsible for making voting decisions.

E. Review and Revisions: The Committee may need to revise the policy to comply with changes in applicable law as these changes affect the investment of the Plans' assets. Until revised or amended by the Committee, the policy shall remain in effect.

1. If there is any conflict between the policy and the Plans, the terms and conditions of the Plans will be followed per applicable regulations related to the laws that govern the Plans.

IV. ATTACHMENT(S)

A. Categories and Benchmarks
B. Investment Ranking Criteria
C. Index Funds Ranking Criteria

V. REFERENCE(S)

A. California Constitution Article XVI § 17 (a)(b) & (c)
B. California Government Code § 53213.5(b), California's incorporation of ERISA Section 404(c)
C. California Government Code § 53609, Deferred compensation funds [457(b)]
D. California Government Code § 7511 (2024), Public Pension and Retirement Plans
E. California Government Code § 7522.02 (2024), California Public Employees' Pension Reform Act of 2013 (PEPRA)
F. Internal Revenue Code (IRC) Section 457(b)
G. Internal Revenue Code (IRC) Section 401(a)

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H. Pension Protection Act (PPA) of 2006

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2026	GA.8064	Deferred Compensation Investments	Administrative

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IX. GLOSSARY

Term	Definition
457(b) Deferred Compensation Plan	A retirement savings plan that allows eligible employees to supplement any existing retirement and pension benefits by saving and investing before-tax dollars through a voluntary salary contribution. Contributions and any earnings on contributions are tax-deferred until money is withdrawn.
401(a) Defined Contribution Plan	A retirement savings plan designed to allow employers to supplement their employees' existing retirement and pension benefits by contributing to the plan on the employee's behalf. Contributions and any earnings on contributions are tax-deferred until money is withdrawn.
CalOptima Health Deferred Compensation Plan Committee	Committee that, with the assistance of the investment consultant, reviews the Plans' Investment Policy and monitors each investment alternative on an ongoing basis.

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ATTACHMENT A – Categories and Benchmarks

Investment categories are defined based on their Morningstar category classifications, which also serve as the peer groups against which investment are assessed. The following list of investment categories and their corresponding benchmarks which may be used in the investment alternative evaluation process, includes but is not limited to:

Investment Alternative Category	***Benchmark/Index***
Money Market-Taxable	BofA US Treasury Bill 3 Mon TR USD
Stable Value	BofA US Treasury Bill 3 Mon TR USD
Guaranteed Account	BofA US Treasury Bill 3 Mon TR USD
Bond	
Ultrashort Bond	Bloomberg US Govt/Credit 1-3 Yr TR USD
Short-Term Bond	Bloomberg US Govt/Credit 1-3 Yr TR USD
Short Government	Bloomberg Government 1-5 Yr TR USD
Intermediate Government	Bloomberg US Govt/Mortgage TR USD
Intermediate Core Bond	Bloomberg US Agg Bond TR USD
Intermediate Core Plus Bond	Bloomberg US Agg Bond TR USD
Long Government	Bloomberg US Government Long TR USD
Long-Term Bond	Bloomberg US Govt/Credit Long TR USD
Inflation-Protected Bond	Bloomberg US Treasury US TIPS TR USD
Corporate Bond	Bloomberg US Credit TR USD
Multisector Bond	Bloomberg US Agg Bond TR USD
High Yield Bond	Bloomberg US HY 2% Issuer Cap TR USD
Bank Loan	Credit Suisse Leveraged Loan TR USD
World Bond	Bloomberg Global Aggregate TR USD
Emerging Markets Bond	JPM EMBI Global TR USD
Nontraditional Bond	Wilshire Liquid Alts TR
Large Cap	
Large Value	Russell 1000 Value TR USD
Large Blend	S&P 500 Index Russell 3000 Index CRSP U.S. Total Market Index
Large Growth	Russell 1000 Growth TR USD
Mid-Cap	
Mid-Cap Value	Russell Mid Cap Value TR USD
Mid-Cap Blend	Russell Mid Cap TR USD S&P Mid Cap 400 Index MSCI U.S. Mid Cap 450 Index CRSP U.S. Mid Cap Index S&P Completion Index DJ US Completion Total Stock Market Index
Mid-Cap Growth	Russell Mid Cap Growth TR USD
Small-Cap	
Small Value	Russell 2000 Value TR USD
Small Cap Blend	Russell 2000 TR USD S&P Small Cap 600 Index

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Investment Alternative Category	*Benchmark/Index*
	MSCI U.S. Small Cap 1750 Index CRSP U.S. Small Cap Index
Small Growth	Russell 2000 Growth TR USD
World Stock	
World Stock	MSCI ACWI NR USD
International	
Foreign Large Value	MSCI ACWI ex USA Value NR USD
Foreign Large Blend	MSCI ACWI ex USA NR USD
Foreign Large Growth	MSCI ACWI ex USA Growth NR USD
Foreign Small/Mid Value	MSCI ACWI ex USA SMID Value NR USD
Foreign Small/Mid Blend	MSCI ACWI ex USA SMID NR USD
Foreign Small/Mid Growth	MSCI ACWI ex USA SMID Growth NR USD
Diversified Emerging Markets	MSCI EM NR USD
Target Date	
Target Date	S&P Target Date Indexes
Risk-based/Hybrid	
Allocation—15% to 30% Equity	23% Russell 3000 TR USD/77% Bloomberg Barclays US Agg Bond TR USD
Allocation—30% to 50% Equity	40% Russell 3000 TR USD/60% Bloomberg Barclays US Agg Bond TR USD
Allocation 50% to 70% Equity	60% Russell 3000 TR USD/40% Bloomberg Barclays US Agg Bond TR USD
Allocation—70% to 85% Equity	78% Russell 3000 TR USD/22% Bloomberg Barclays US Agg Bond TR USD
Allocation—85%+ Equity	93% Russell 3000 TR USD/7% Bloomberg Barclays US Agg Bond TR USD
World Allocation	60% MSCI ACWI NR/40% Bloomberg Barclays Global Agg TR
Specialty	
Real Estate	FTSE NAREIT Equity REITs TR USD
Global Real Estate	FTSE EPRA/NAREIT Developed NR USD
Commodities Broad Basket	Bloomberg Commodity TR USD
Long-Short Equity	Barclay Hedge Fund Index
Market Neutral	BofA US Treasury Bill 3 Mon TR USD
Multialternative	Wilshire Liquid Alts TR
Natural Resources	S&P North American Natural Resources TR
Tactical Allocation	50% MSCI ACWI NR / 50% Bloomberg US Agg Bond TR USD

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APPENDIX B –Investment Ranking Criteria

The criteria used to evaluate each plan investment alternative, except as otherwise noted in the Investment Policy Statement, may include, but not limited to, the following:

1. **Total Return (trailing 1, 3, 5 and 10 year returns)** – measures the performance of an investment over a given period, including income from dividends and interest, plus any appreciation or depreciation in the market value of the investment. Total return values longer than 1 year are typically annualized for ease of comparison.

2. **Rolling Period Returns (12 month periods over 5 years)** – A single period return measures performance over one specified time frame, such as five years. A rolling period return divides a longer time frame into smaller time periods. A rolling 12-month return over five years would start out by calculating a single period return over the first twelve months. Next, it would calculate the 12-month return for months 2-13. The process would continue until finally reaching the 12-month period spanning months 48-60. The final rolling 12-month return figure would reflect the average of all of the rolling periods returns over that five-year time period.

3. **Batting Average (monthly over 10 years) -** Measures the consistency with which a manager has outperformed a peer group average. Displays the ratio of monthly outperformance observations to monthly underperformance observations over a ten year measurement window. The higher the ratio, the more consistent the outperformance. Compares many short periods distinctly, unlike rolling returns, which compares many longer periods that overlap. .

4. **Modified Sharpe Ratio** – A risk-adjusted measure of performance that is calculated by subtracting the risk-free rate of return (the US Treasury Bill is typically used) from the portfolio return and dividing the result by the portfolio's standard deviation. A higher Sharpe ratio indicates that the portfolio was able to generate a higher return per unit of risk.

5. **Alpha** (five years) – A risk-adjusted measure of performance, that is equal to the difference between a portfolio's actual return and its expected performance given its level of risk as measured by beta. Alpha can also be viewed as an abnormal level of return in excess of what might be predicted by an equilibrium pricing model like the Capital Asset Pricing Model (CAPM).

6. **Up Market Capture Ratio** (ten years) – A ratio that measures the overall performance of a portfolio during rising markets. This measure analyzes how well a portfolio (or an investment manager) performed relative to its benchmark index during periods when the benchmark rose. For example, an up-market capture ratio of 108% (for a given period of time) means that the portfolio gained 8% more than its benchmark during the specified time period.

7. **Down Market Capture Ratio** (ten years) – A ratio that measures the overall performance of a portfolio during falling markets. This measure analyzes how well a portfolio (or an investment manager) performed relative to its benchmark index during periods when the benchmark fell. For example, a down-market capture ratio of 95% (for a given period of time) means that the portfolio lost 5% less than its benchmark during the specified time period.

8. **R-Squared** (style consistency) – A statistical metric that ranges from zero to 100 and measures the percentage of portfolio's performance that is explained by the movement of its benchmark index. R-Squared is helpful in assessing the reliability of alpha and beta in explaining a portfolio risk and return characteristics. An r-squared of 100 would mean that the portfolio's performance movements

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are perfectly correlated with those of the benchmark over time and would suggest that alpha and beta may be relied upon with a high degree of confidence.

9. **Expense Ratio** – The percentage of investment alternative assets, net of reimbursements, used to pay for operating expenses and management fees, including 12b-1 fees, administrative fees, and all other asset-based costs incurred by the investment alternative, except brokerage costs. Investment alternative expenses are reflected in the investment alternative's NAV. Sales charges are not included in the expense ratio. The Prospectus Net Expense Ratio is collected annually from an investment alternative's prospectus.

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APPENDIX C –Index Funds Ranking Criteria

The criteria used to evaluate each Index Fund alternative may include, but not limited to, the following:

1. **Expense Ratio** – The percentage of investment alternative assets, net of reimbursements, used to pay for operating expenses and management fees, including 12b-1 fees, administrative fees, and all other asset-based costs incurred by the investment alternative, except brokerage costs. Investment alternative expenses are reflected in the investment alternative 's NAV. Sales charges are not included in the expense ratio. The Prospectus Net Expense Ratio is collected annually from an investment alternative's prospectus.

2. **Tracking Error** – A measure of the difference in returns between an investment and a benchmark. Tracking error is reported as a standard deviation of the difference between the returns of an investment and its benchmark.

3. **R-Squared** – A statistical metric that ranges from zero to 100 and measures the percentage of portfolio's performance that is explained by the movement of its benchmark index. R-Squared is helpful in assessing the reliability of alpha and beta in explaining a portfolio risk and return characteristics. An r-squared of 100 would mean that the portfolio's performance movements are perfectly correlated with those of the benchmark over time and would suggest that alpha and beta may be relied upon with a high degree of confidence.

4. **Beta** – A measure of the volatility, or systematic risk, of an investment in comparison to a market index as a whole. Beta is calculated using regression analysis. Beta represents the tendency of an investment's returns to respond to moves in the market or index that it's calculated against. A beta of 1 indicates that the investment's price moves with the market. A beta of less than 1 means that the investment is theoretically less volatile than the market. A beta of greater than 1 indicates that the investment's price is theoretically more volatile than the market. The reliability of an investment's beta is a function of the investment's r-squared value in relation to the benchmark. A high r-squared value signifies that the beta measures is reliable, while a low r-squared signifies that it is potentially inaccurate.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

8. Consider Adoption of Investment Policy Statement for CalOptima's 457(b) Deferred Compensation Plan

Contacts

Brigette Hoey, Executive Director, Human Resources, (714) 246-8405
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

Recommend approval of the proposed Investment Policy Statement for CalOptima's 457(b) Deferred Compensation Plan

Background

In 1994, the CalOptima Board of Directors approved the establishment of a deferred compensation program (Program) for employees under Section 457(b) of the Internal Revenue Code, including a deferred compensation plan (Plan). Due to changes in Section 457 over the years, an amended and restated Plan was adopted in 2005. A subsequent amended and restated Plan was adopted in 2011 that provided for the rights of designated beneficiaries who are not the employee's spouse in the event of the death of the employee. A subsequent amended and restated Plan was adopted in 2013 that: (1) added a Roth 457 option (Roth Option) under the Plan; (2) established the composition of the CalOptima Deferred Compensation Committee (Committee) to include the Executive Director of Human Resources as Committee Chair, and the Chief Financial Officer or designee, as well as additional members and future replacement members appointed by the Committee Chair; and (3) directed the Committee to follow the "prudent person" standard generally applicable to California government retirement plans in selection of investment options for the Deferred Compensation Investment Policy (Investment Policy).

Discussion

The Committee, in consultation with CalOptima's independent investment advisor SageView Advisory Group, LLC, prepared the proposed Investment Policy Statement, which is intended to establish the policies and guidelines for CalOptima's Plan and to assist the Committee in effectively selecting, monitoring, and evaluating investment alternatives made available to Plan participants. The Investment Policy Statement outlines and prescribes a prudent and acceptable investment philosophy and sets out the investment management procedures.

The Board delegated authority to the Committee to interpret the Plan and adopt rules and regulations for the administration of the Plan, and to interpret, alter, amend, or revoke any rules and regulations so adopted, provided that they are not inconsistent with the provisions of the Plan and that they conform with Section 457(b) of the Code and any applicable regulations thereunder.

For oversight and transparency purposes, the Committee recommends that the initial adoption of the Investment Policy Statement be reviewed and approved by the FAC and recommended for approval by

the Board. Staff will return to the FAC and Board with any future substantive revisions to the Investment Policy Statement for review and approval.

Fiscal Impact

The recommended action to approve the Investment Policy Statement for CalOptima's 457(b) Deferred Compensation Plan is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

Adoption of the proposed Investment Policy Statement will establish the policies and guidelines for the administration of the Plan. Bringing the Investment Policy Statement to the FAC and the Board for review and adoption provides oversight and transparency desired by the Committee.

Concurrence

Board of Directors' Finance and Audit Committee
Gary Crockett, Chief Counsel

Attachments

1. Investment Policy Statement

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

INVESTMENT POLICY STATEMENT

Orange County Health Authority dba CalOptima
Orange County Health Authority 457(b) Deferred Compensation Plan

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Purpose of the Investment Policy Statement

This Investment Policy Statement establishes the policies and guidelines for the Orange County Health Authority 457(b) Deferred Compensation Plan (the "Plan") and is intended to assist the CalOptima Deferred Compensation Committee (the "Committee") in effectively selecting, monitoring and evaluating investment alternatives made available to participants under the Plan. It outlines and prescribes a prudent and acceptable investment philosophy and sets out the investment management procedures.

Purpose of the Plan

The Plan was established to provide a retirement savings program for eligible employees of the Orange County Health Authority dba CalOptima (the "Plan Sponsor"). The Plan is maintained for the exclusive purpose of benefiting the Plan participants and their beneficiaries. The Plan intends to operate in accordance with all applicable state and federal laws and regulations.

The goal of the Plan is to provide a framework for eligible employees of the Plan Sponsor to establish a savings and investment program for their retirement. While Plan participants are ultimately responsible for their own investment decisions, the Plan Sponsor will endeavor to provide an appropriate range of investment alternatives, allowing each individual participant to invest in accordance with his or her own time horizons, risk tolerance, and retirement goals.

In evaluating the investment alternatives for the Plan, the Plan Sponsor will take into account all Plan demographics.

The objective of the Plan is specifically intended to:

- Promote retirement savings while encouraging employee participation as a vehicle to accumulate assets to provide for a portion of their retirement needs
- Provide Plan participants with a wide and suitable range of asset categories and investment alternatives that are intended to help participants meet their retirement goals and investment objectives
- Attract and retain outstanding employees by providing diverse investment options
- Obtain Plan investment alternatives at reasonable costs and control overall investment related service costs
- Establish investment objectives and standards for the investment options offered to assure that the assets are managed in accordance with the investment policy
- Establish formal criteria and process to evaluate investment performance results

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- Provide formal process for reviewing and modifying the investment policy; and
- Meet the fiduciary responsibility of the Deferred Compensation Plan.

Statement of Responsibilities

The following parties associated with the Plan, appointed by the Plan Sponsor, shall discharge their respective responsibilities in accordance with all applicable fiduciary standards as follows: (1) in the sole interest of the Plan participants and beneficiaries; and (2) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and of like aims. All Plan fiduciaries shall complete education and ethics training that covers all aspects of their duties and responsibilities as fiduciaries of the Plan, including, but not limited to, best practices, plan compliance, legislative and regulatory activities, as well as investment alternative selection, monitoring and replacement.

A. Deferred Compensation Committee: The members of the Committee are Plan fiduciaries and supervise the investment of the assets of the Plan, and make decisions concerning investment alternatives available under the Plan. In adopting this Investment Policy Statement, it is the intention of the Committee that the oversight of the investment portion of the Plan will be the responsibility of the Committee. The Committee will follow best practices, which include, but may not be limited to, the Duty of Loyalty, the Duty of Prudence, the Duty to Diversify, and the Duty to Follow the Plan Documents. The Committee shall be responsible for the Plan- level investment selection process, as set forth in this Investment Policy Statement, but is not responsible for the individual fund performance and does not guarantee positive investment results. The Committee may select a qualified Investment Consultant whose duties may include assisting in the selection, evaluation, monitoring of investment options and other administrative issues.

B. Trustee: The Trustee of the Plan is charged with safekeeping the securities as well as collecting and disbursing the Plan assets and periodic accounting statements.

C. Recordkeeper: The Recordkeeper has responsibilities that include, but are not limited to, the following: maintaining participant records, administering participant directions, reporting to the Plan Sponsor, reporting to participants, allocating contributions, administering loans, and preparing the required regulatory documents.

D. Investment Consultant: If Plan Sponsor elects to use an Investment Consultant, the Investment Consultant is charged with the responsibility of advising the Committee

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on investment policy, advising on the selection of investment alternatives, providing performance analysis and monitoring services, and educating the Committee on economic and investment trends that may impact the performance of the selected and available investment alternatives. The Investment consultant shall evaluate changes in legislation and regulations to ensure compliance regarding investment matters. The Investment Consultant, along with the Committee, shall be responsible for the Plan-level investment selection process, as set forth in this Investment Policy Statement, but is not responsible for the individual fund performance and does not guarantee investment results.

Investment Choices

The Plan intends to provide a broad range of investment alternatives. This includes having, at a minimum, three diversified investment alternatives that are sufficient in permitting the participants to select from a broad range of risk and return characteristics that will give participants the opportunity to develop an investment portfolio which will meet their desired risk and return requirements. Diversification, however, does not ensure a profit or protect against loss in a declining market.

All investment choices will be publicly available mutual funds, institutional trusts, or similar vehicles. All investments being offered will fluctuate in value with market conditions and, when redeemed, may be worth more or less than the amount originally invested. The chosen investment alternatives will be selected on the basis of their compatibility with Plan participants' needs and regulatory recommendations. Each of the chosen investment alternatives will be designed to follow a specific stated investment objective.

Qualified Default Investment Alternative (ODIA}

Although the Committee intends that participants will direct the investment of their assets held under the Plan, there may be circumstances under which participants do not provide direction regarding the investment of their individual accounts. In such instances, participant accounts will be invested in the Plan's default investment alternative. The Committee's intention is for the Plan to comply with the Pension Protection Act of 2006 by offering a default investment alternative that complies with all of the conditions required of a Qualified Default Investment Alternative (QDIA).

The Committee may elect to utilize a multi-asset class investment alternative, such as age-appropriate target-date funds, as the QDIA. Periodically, as participant demographics or market conditions require, the Committee shall review and document the process for monitoring and selecting the QDIA, taking into account such factors as the philosophy and goals of the Plan Sponsor as well as the needs and abilities of the participants and beneficiaries.

The specific target date portfolio for a participant or beneficiary who fails to make an investment election will be based on the participant's or beneficiary's date of birth and

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an assumed normal retirement date of age 65.

Selection of Investment Alternatives

The Plan will take a two-tiered approach to Investment alternative selection. Quantitative and qualitative screens are used as follows:

Quantitative Screening (including but not limited to):

- Investment track record
- Investment risk
- Investment risk/return
- Investment style analysis
- Performance consistency
- Investment cost
- Turnover ratio

Qualitative Screening (Investments that pass the quantitative screens will be reviewed for characteristics that include but are not limited to):

- Investment-style variations
- Portfolio concentration
- Asset size and growth

Interviews with portfolio managers and/or analysts will also be conducted if deemed necessary.

Selected alternatives will be reviewed to ensure that there are no additional factors that would make them unsuitable for inclusion in the Plan. Each alternative will also be examined to ensure that it appropriately complements the overall diversification and risk and return parameters of the entire Plan investment lineup.

In addition to diversification and risk tolerance considerations, investment expenses will be considered in the selection of investment alternatives. The Committee will regularly review all costs associated with the management of the Plan's investment program. These costs include the following:

- Expense ratios of each investment alternative against the appropriate peer group.
- Trustee and custodial fees for holding assets, collecting income, and paying disbursements.
- Plan administrative fees, including record keeping fees and other fees associated with services the Plan receives, such as compliance testing fees, audit fees, fees for communication services, etc.

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Evaluation Methodology

The Committee anticipates using the following criteria in selecting and monitoring Plan investment alternatives. Each Plan investment alternative should be evaluated on an ongoing basis using several measures that quantify the expenses, returns and risk-adjusted performance of each investment alternative within its peer group.

Each Plan investment alternative should be reviewed at least annually against its peer group and benchmark index to assess the performance and quality of each offering. The list of criteria that may be used for evaluation is included as Appendix B of this document and may be updated by the Committee, as necessary.

As noted in Appendix A, whenever possible, each investment alternative is benchmarked to a specific market index, and performance is evaluated and compared to a relevant peer group using Morningstar category classifications. Each criterion for an investment alternative is given a peer group ranking, shown as a percentage. As an example, a criterion ranking of 10% indicates an investment alternative is in the top 10% of its peer group for said criterion. The rankings for all criteria are then weighted and averaged to give an investment alternative its average ranking score. The lower the average ranking score, the better. In general, an investment alternative with an average ranking score of 25% would be more attractive than a comparable investment alternative with a ranking score of 50%. An overall ranking score is used to indicate where an investment alternative places in relation to the scores of the other investment alternatives in its category. Generally, investment alternatives are divided into categories of deciles and quartiles.

Peer group rankings require a three-year history to ensure an accurate evaluation of the investment alternative. Any investment alternative with fewer than three years of history will not be evaluated using this method. In the event there is a sufficiently similar investment alternative, the Committee may elect to use its history for evaluation purposes. Sufficiently similar investment alternatives may include:

- Alternate share classes of the same product.
- Other products, such as collective investment trusts (CITs), separate accounts or recordkeeper sub-advised investment alternatives, that are managed by the same portfolio management team according to a substantially similar investment strategy.

In addition to the quantitative methodology described above, many qualitative criteria and possible warning signs are monitored to highlight an investment alternative's potential exposure to risk that may make it unsuitable as a retirement Plan investment

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option. The warning signs may include (but are not limited to):

- Above-average operating expenses
- Above-average style drift (as determined by returns-based and holdings-based analyses)
- High degrees of portfolio concentration among individual holdings
- High degrees of portfolio concentration among economic sectors
- Above-average performance volatility
- Above-average portfolio turnover
- Below-average Alpha
- Below-average manager tenure and/or above-average turnover
- Rapid growth in assets
- Significantly positive or negative cash flows
- Unusual levels of corporate scrutiny; poor public perception
- For bond portfolios, very low average credit quality relative to peers
- For bond portfolios, significantly above- or below-average portfolio durations
- Recent changes to or concerns with the firm structure/ ownership
- Recent changes to or concerns with the corporate management team structure

Other Investment Evaluation Criteria

The Committee recognizes that certain investment alternatives present challenges in monitoring, given the nature of the investment alternative's portfolio and peer group. Thus, there are several instances where Investment alternatives will not fit neatly into the monitoring framework set forth herein. Therefore, the Committee must consider additional or different factors when evaluating certain investments. The following are common examples of investments requiring a different point of view, whether the Committee has included them In the current menu or may consider doing so in the future.

Multi-asset class *investments:* For multi-asset class investment alternatives, such as target-date funds, the asset allocation and glide path should be evaluated taking into account factors such as generally accepted investment theories and prevailing investment industry practices, and goals of the plan, the philosophy of the fiduciaries regarding asset class diversification and the desired relationship of risk (or volatility) and potential return, and the needs and abilities of the participants and beneficiaries. The Committee, with the assistance of the Investment Consultant, expects to engage in a process to identify and consider those goals, preferences, needs and abilities and to select a default investment consistent with that analysis.

As the process for comparing multi-asset class investments, including target-date funds, differs from the process used for other investment selections in several respects. Criteria listed elsewhere in this Investment Policy Statement may not apply.

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Index fund: The goal of an index fund is to closely mirror the performance of a predetermined index at a reasonable cost. The criteria which may be used to evaluate index funds is set forth in Appendix C and may be updated from time-to-time at the Committee's discretion.

Each index fund will be compared to a standard index for its respective category classification and assigned a ranking in each of the four criterions. The rankings for all criteria are then weighted and averaged to give an investment alternative its average ranking score. Index funds with an average ranking score in the top 75% of the investment alternative's in a category are given a passing score ("Pass"), while investment alternatives below in the lowest 25% of investment alternatives are given a failing score ("Fail").

Stable value investments: The goal of a stable value fund is to preserve capital. Stable value investments come in several structures: pooled/comingled funds, insurance separate accounts, and guaranteed investment contracts (GICs)/insurance general accounts or derivatives thereof.

One investment characteristic of these products is their investment in various sectors of the bond market. Thus, part of the evaluation will hinge on the evaluation of the underlying bond portfolio. The other important characteristic is financial credit worthiness of the insurance companies that issue wrap contracts to protect the book value of the bond portfolios. Some additional unique (albeit not exhaustive) metrics and characteristics that warrant evaluation include market-to-book value ratio, participant /plan sponsor withdrawal restrictions, crediting rate and wrap structure. For insurance general accounts, the Committee should at a minimum review the crediting rate, withdrawal restrictions, and credit worthiness ratings of the insurer.

Monitoring of Investment Policy and Investment Performance

The Committee, with the assistance of the Investment Consultant, will review the Plan's Investment Policy and monitor each investment alternative on an ongoing basis. The Committee will periodically evaluate the investment results of the investment alternatives.

In addition, the Committee shall maintain a "Watch List" for investment alternatives that are not meeting certain objectives. An investment alternative will be placed on the Watch List if it meets either at least two of the conditions “a” through “g” below or condition “h”:

a. Performance below 50% of its peer group for a three-year period
b. Performance below 50% of its peer group for a five-year period
c. Performance below 50% of its peer group for a ten0year period
d. Performance below its benchmarks for a three-year period
e. Performance below its benchmarks for a five-year period

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f. Performance below its benchmarks for a ten-year period
g. A Morningstar rating of 2 or below
h. Extenuating circumstances, such as:

    1. Change in fees
    2. Change of portfolio manager
    3. Change of sub-advisor
    4. Any violations of SEC rules or regulations
    5. Performance will be considered over a minimum of a three-year period and a maximum of a ten-year period unless a shorter-term underperformance is so severe that it warrants the Committee's immediate consideration for removal.

Investment alternatives that fail to meet qualitative criteria {i.e.: manager changes, fund company reorganizations, strategy changes) will be put on the Watch List by the Committee.

To be in good standing and removed from the Watch List, an investment alternative must not have more than one of the Watch List criteria "a" through "g" above. However, an investment alternative may have extenuating circumstances that warrants continuation on the Watch List.

The Committee shall have the authority to establish, modify, amend, or adjust acceptable performance measurement standards by which each investment alternative is to be evaluated.

Final selection, replacement and/or removal of an investment alternative shall be completed only after conducting a thorough review of the identified investment alternative.

An investment alternative on the Watch List will be removed from participant investment options if it is determined that extenuating circumstances are not in accordance with prudent investment standards or when conditions "a" through "e" below apply:

a. Performance below 50% of its peer group for a five-year period
b. Performance below 50% of its peer group for a ten-year period
c. Performance below its benchmarks for a five-year period
d. Performance below its benchmarks for a ten-year period
e. A Morningstar rating of 2 or below
f. Extenuating circumstances, such as:
    1. Change in fees
    2. Change of portfolio manager
    3. Change of sub-advisor
    4. Any violations of SEC rules or regulations
    5. Performance will be considered over a minimum of a three-year period and a maximum of a ten-year period unless a shorter-term underperformance is so severe that it warrants the Committee's immediate consideration for removal.

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The Committee has discretion to retain any investment alternative if it remains a prudent option.

The Recordkeeper will communicate to all eligible participants the investment alternative(s) subject to removal.

After an investment alternative is removed, all existing balances and future contributions will be moved from the removed investment alternative to a similar existing investment alternative or a replacement fund. No new contributions or transfers will be accepted into a removed investment alternative.

The Plan will provide for regular communication of investment and Plan information in addition to necessary updates to inform participants of changes to the Plan. The Plan will not be responsible for providing investment advice to participants.

Proxy Voting

Should the Committee elect to participate in a proxy vote, the Committee shall be required to provide a detailed analysis of voting activities on an annual basis (calendar year). When voting proxies, the Committee will vote to the best of their abilities in the best interest of the Plan's participants. The Committee is not required to participate in all proxy votes related to the investments in the Plan. Investment Consultant is able to offer general guidance and provide clarification with respect to the process of voting by proxy but will not be responsible for making vote decisions.

Note: The *provisions* of *this Investment Policy Statement* are *guidelines only. The fiduciaries* are *not required to follow them. Instead, fiduciaries* are *expected to* exercise *independent judgment for the benefit of the participants.*

Review and Revisions

The Committee reserves the right to amend the Investment Policy Statement at any time it deems such amendment to be necessary or to comply with changes in applicable law as these changes affect the investment of the Plan's assets. Until revised or amended by the Committee, the Investment Policy Statement shall remain in effect.

If there is any conflict between the Investment Policy Statement and the Plan, the terms and conditions of the Plan will control.

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ADOPTION

CalOptima Deferred Compensation Committee Members:

x_____

(Print Name) (Date)

x._____

(Print Name) (Date)

x._____

(Print Name) (Date)

x_____

(Print Name) (Date)

x._____

(Print Name} (Date)

x_____

(Print Name) (Date)

x_____

(Print Name) (Date)

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APPENDIX A- Categories and Benchmarks

Investment categories are defined based on their Morningstar category classifications, which also serve as the peer groups against which investment are assessed. The following list of investment categories and their corresponding benchmarks which may be used in the investment alternative evaluation process, includes but is not limited to:

Investment Alterative	***Benchmark</Index***
Money Market-Taxable	BofAML US Treasury Bill 3 Mon TR USD
Stable Value	Hueler Stable Value Index
Guaranteed Account	Hueler Stable Value Index
Bond	
Ultrashort Bond	Bloomberg Barclays US Govt/Credit 1-3 Yr TR USD
Short-Term Bond	Bloomberg Barclays US Govt/Credit 1-3 Yr TR USD
Short Government	Bloomberg Barclays Government 1-5 Yr TR USD
Intermediate Government	Bloomberg:(Barclays US Govt/Mortgage TR USD
Intermediate Core Bond	Bloomberg Barclays US Aee Bond TR USO
Intermediate Core Plus Bond	Bloomberg Barclays US Ar!.2 Bond TR USO
Long Government	Bloomberg Barclays US Government Long TR USD
Long-Term Bond	Bloomberg Barclays US Govt/Credit Long TR USO
Inflation-Protected Bond	Bloomberg Barclays US Treasury US TIPS TR USO
Corporate Bond	Bloomberg Barclavs US Credit TR USD
Multisector Bond	Bloomberg Barclays US Agg Bond TR USO
High Yield Bond	Bloomberg Barclays US HY 2% Issuer Cap TR USO
Bank Loan	Credit Suisse Leveraged Loan TR USD
World Bond	Bloomberg: Barclays Global-Aggregate TR USO
Emerging Markets Bond	JPM EMBI Global TR USO
Nontraditional Bond	Wilshire Liquid Alts TR
LargeCa1J	
Large Value	Russell 1000 Value TR USO
Large Blend	S&P 500 Index Russell 3000 Index CRSP U.S. Total Market Index
Large Growth	Russell 1000 Growth TR USO
Mid-Cap	
Mid-Cap Value	Russell Mid Cap Value TR USO

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Mid-Cap Blend	Russell Mid Cap TR USO S&P Mid Cap 400 Index MSCI U.S. Mid Cap 450 Index CRSP U.S. Mid Cap Index S&P Completion Index DJ US Completion Total Stock Market Index
Mid -Cap Growth	Russell Mid Cap Growth TR USO
Small-Cap	
Small Value	Russell 2000 Value TR USO

Investment Alternative	***Benchmark/Index***
Small Cap Blend	Russell 2000 TR USO S&P Small Cap 600 Index MSCI U.S. Small Cap 1750 Index CRSP U.S. Small Cap Index
Small Growth	Russell 2000 Growth TR USO
World Stock	
World Stock	MSCI ACWI NR USO
International	
Foreign Large Value	MSCI ACWI ex USA Value NR USO
Foreign Large Blend	MSCI ACWI ex USA NR USO
Foreign Large Growth	MSCI ACWI ex USA Growth NR USO
Foreign Small/ Mid Value	MSCI ACWI ex USA SMID Value NR USO
Foreign Small/ Mid Blend	MSCI ACWI ex USA SMID NR USO
Foreign Small/ Mid Growth	MSCI ACWI ex USA SMID Growth NR USO
Diversified Emerging Markets	MSCI EM NR USO
Target Date	
Target Date	S&P Target Date Indexes
Risk-base/Hybrid	
Allocation-15% to 30% Equity	23% Russell 3000 TR USD/77% Bloomberg Barclays US Agg Bond TR USO
Allocation-30% to 50% Equity	40% Russell 3000 TR USD/60% Bloomberg Barclays US Agg. Bond TR USO
Allocation 50% to 70% Equity	60% Russell 3000 TR USO/40% Bloomberg Barclays US Agg Bond TR USO
Allocation- 70% to 85% Equity	78% Russell 3000 TR USD/22% Bloomberg Barclays US Agg Bond TR USO
Allocation-8 5%+ Equity	93 % Russell 3000 TR USD/7% Bloomberg Barclays US Agg Bond TR USO
World Allocation	60% MSCI ACWI NR/40% Bloomberg Barclays Global Agg TR
Specialty	
Real Estate	FTSE NAREIT Equity REITs TR USO
Global Real Estate	FTSE EPRA/NAREIT Developed NR USO
Commodities Broad Basket	Bloomberg Commodity TR USO
Long-Short Equity	Barclay Hedge Fund Index
Market Neutral	BofAML US Treasury Bill 3 Mon TR USO
Multi-alternative	Wilshire Liquid Alts TR
Natural Resources	S&P North American Natural Resources TR
Tactical Allocation	50% MSCI ACWI NR / 50 % Bloomberg Barclays US Agg Bond TR USO

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APPENDIX B - Investment Ranking Criteria

The criteria used to evaluate each plan investment alternative, except as otherwise noted in the Investment Policy Statement, may include, but not limited to, the following:

1. Total Return (trailing 1, 3, 5, and 10 year returns) - measures the performance of an investment over a given period, including income from dividends and interest, plus any appreciation or depreciation in the market value of the investment. Total return values longer than 1 year are typically annualized for ease of comparison.

2. Rolling Period Returns (12 month periods over 5 years) - A single period return measures performance over one specified time frame, such as five years. A rolling period return divides a longer time frame into smaller time periods. A rolling 12-month return over five years would start out by calculating a single period return over the first twelve months. Next, it would calculate the 12-month return for months 2-13. The process would continue until finally reaching the 12-month period spanning months 48-60. The final rolling 12-month return figure would reflect the average of all of the rolling periods returns over that five-year time period.

3. Rolling Period Returns (36 month periods over 10 years) - A rolling 36-month return over ten years would start out by calculating a single period return over the first thirty-six months. Next, it would calculate the 36-month return for months 2-37. The process would continue until finally reaching the 36-month period spanning months 85-120. The final rolling 36- month return figure would reflect the average of all of the rolling periods returns over that ten-year time period.

4. **Sharpe Ratio** - A risk-adjusted measure of performance that is calculated by subtracting the risk-free rate of return (the US Treasury Bill is typically used) from the portfolio return and dividing the result by the portfolio's standard deviation. A higher Sharpe ratio indicates that the portfolio was able to generate a higher return per unit of risk.

5. **Alpha** (five years) - A risk-adjusted measure of performance, that is equal to the difference between a portfolio's actual return and its expected performance given its level of risk as measured by beta. Alpha can also be viewed as an abnormal level of return in excess of what might be predicted by an equilibrium pricing model like the Capital Asset Pricing Model **{CAPM).**

6. Up **Market** Capture Ratio (five years) - A ratio that measures the overall performance of a portfolio during rising markets. This measure analyzes how well a portfolio (or an investment manager) performed relative to its benchmark index during periods when the benchmark rose. For example, an up-market

capture ratio of 108% (for a given period of time) means that the portfolio gained 8% more than its benchmark during the specified time period.

7. **Down Market Capture Ratio** (five years) - A ratio that measures the overall performance of a portfolio during falling markets. This measure analyzes how well a portfolio (or an investment manager) performed relative to its benchmark index during periods when the benchmark fell. For example, a down-market capture ratio of 95% (for a given period of time) means that the portfolio lost 5% less than its benchmark during the specified time period.

8. **R-Squared** (style consistency) - A statistical metric that ranges from zero to 100 and measures the percentage of portfolio's performance that is explained by the movement of its benchmark index. R-Squared is helpful in assessing the reliability of alpha and beta in explaining a portfolio risk and return characteristics. An r-squared of 100 would mean that the portfolio's performance movements are perfectly correlated with those of the benchmark over time and would suggest that alpha and beta may be relied upon with a high degree of confidence.

9. Expense Ratio - The percentage of investment alternative assets, net of reimbursements, used to pay for operating expenses and management fees, including 12b-1 fees, administrative fees, and all other asset-based costs incurred by the investment alternative, except brokerage costs. Investment alternative expenses are reflected in the investment alternative's NAV. Sales charges are not included in the expense ratio. The Prospectus Net Expense Ratio is collected annually from an investment alternative's prospectus.

APPENDIX C - Index Funds Ranking Criteria

The criteria used to evaluate each Index Fund alternative may include, but not limited to, the following:

1. **Expense Ratio** - The percentage of investment alternative assets, net of reimbursements, used to pay for operating expenses and management fees, including 12b-1 fees, administrative fees, and all other asset-based costs incurred by the investment alternative, except brokerage costs. Investment alternative expenses are reflected in the investment alternative 1s NAY. Sales charges are not included in the expense ratio. The Prospectus Net Expense Ratio is collected annually from an investment alternative •s prospectus.

2. Tracking Error - A measure of the difference in returns between an investment and a benchmark. Tracking error is reported as a standard deviation of the difference between the returns of an investment and its benchmark.

3. **R-Squared** - A statistical metric that ranges from zero to 100 and measures the percentage of portfolio's performance that is explained by the movement of its benchmark index. R- Squared is helpful in assessing the reliability of alpha and beta in explaining a portfolio risk and return characteristics. An r-squared of 100 would mean that the portfolio's performance movements are perfectly correlated with those of the benchmark over time and would suggest that alpha and beta may be relied upon with a high degree of confidence.

4. Beta - A measure of the volatility, or systematic risk, of an investment in comparison to a market index as a whole. Beta is calculated using regression analysis. Beta represents the tendency of an investment's returns to respond to moves in the market or index that it's calculated against. A beta of 1 indicates that the investment's price moves with the market. A beta of less than 1 means that the investment is theoretically less volatile than the market. A beta of greater than 1 indicates that the investment's price is theoretically more volatile than the market. The reliability of an investment's beta is a function of the investment's r-squared value in relation to the benchmark. A high r-squared value signifies that the beta measures is reliable, while a low r-squared signifies that it is potentially inaccurate.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 4, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

6. Authorize Amendments to CalOptima Health's Primary and Secondary Agreements with the California Department of Health Care Services Related to Calendar Year 2026 Final Draft Rate Update

Contacts

Nancy Huang, Chief Financial Officer, (657) 235-6935
John Tanner, Chief Compliance Officer, (657) 235-6997

Recommended Action

Authorize execution of amendments to the Primary and Secondary Agreements between the California Department of Health Care Services and CalOptima Health related to Calendar Year 2026 final draft rate update.

Background

The purpose of this COBAR is to request that the Board of Directors (Board) authorize amendments to CalOptima Health's Primary and Secondary Agreements with the Department of Health Care Services (DHCS) related to Calendar Year (CY) 2026 final draft rate changes. These agreements will be signed by the CalOptima Health Board Chair in December 2025 to meet DHCS's deadline.

As a county organized health system, CalOptima Health contracts with DHCS to provide health care services to Medi-Cal members in Orange County. CalOptima Health has a Primary and Secondary Agreement with DHCS.

- The Primary Agreement contains, among other terms and conditions, the payment rates CalOptima Health receives from DHCS to provide health care services.
- The Secondary Agreement is a companion agreement to CalOptima Health's Primary Agreement and covers specific Medi-Cal state-supported services for CalOptima Health's members enrolled under the Primary Agreement.

In January 2024, CalOptima Health entered into new Primary and Secondary Agreements with DHCS. The new Primary Agreement is Agreement 23-30235, and the new Secondary Agreement is Agreement 23-30267. The amendments to the new agreements are summarized in Attachment 1. Annual amendments for the DHCS Primary and Secondary agreements are a routine occurrence. The main changes in the current amendments are updates to the CY 2026 final draft rates.

Discussion

Calendar Year (CY) 2026 Primary and Secondary Agreement Final Draft Rates

Overview

The CalOptima Health Board Chair will be signing finalized CY 2026 Contract Amendments in December 2025 to meet DHCS' deadline. Staff requests the CalOptima Health Board of Directors

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authorize the Chair's execution of the amendments with DHCS. The anticipated impact of these CY 2026 final draft rate changes is identified in the Fiscal Impact section.

The mainstream capitation rates for January 1, 2026, through December 31, 2026, for CalOptima Health's Primary Agreement and Secondary Agreements were first sent to CalOptima Health as draft rates in September 2025 and as final draft rates in November 2025.

DHCS noted the CY 2026 final draft rates may be amended or updated for reasons such as policy changes, enrollment-related items, or risk adjustments. Should these reasons result in substantive changes to the CY 2026 final draft rates, staff will return to the Board for subsequent consideration.

Detailed Discussion

The CY 2026 final draft rates include the following updates:

Base Data Adjustments

- Utilizes a January – June 2024 half year base with the following adjustments/noteworthy items:
    - Separate and distinct Unsatisfactory Immigration Status (UIS) and Satisfactory Immigration Status (SIS) base from the start of the base development process.
    - UIS ramp-up adjustment: Adjustments applied to the Adult and Affordable Care Act Optional Expansion (ACA OE) UIS population to recognize potential ramp-up of services specific to the age 26 – 49 UIS expansion population.
    - Removal of maternity care, value-added services, and Institution for Mental Diseases from the base data.
    - Long-Term Care (LTC) ramp-up: Adjustment applied to the base data to account for under-representation of utilizers in the base period.
    - Efficiency adjustments for the following:
        - Potential avoidable costs due to reimbursement inefficiencies for physician administered drugs billed via Healthcare Common Procedure Coding System codes.
        - Potentially preventable or preemptive low acuity non-emergent emergency department visits.
        - Potentially preventable admissions.

Trend Data Analysis

- Incremental adjustments to trends on a rating region basis to ensure the developed rates are more in line with emerging experience.
- Community Supports trends were updated, reviewing emerging experience beyond the base period.
- Enhanced Care Management (ECM) trends were updated by reviewing emerging ECM enrollment experience through Quarter 2 2025 and revising the resulting per member per month
- (PMPM) calculation based on revised ECM and mainstream projected enrollment.

Population Acuity Adjustments

- Adjustment for SIS population was updated to account for the acuity impacts due to further enrollment declines into CY 2026, primarily driven by the sunsetting of the temporary eligibility flexibilities in July 2025, in use by DHCS since late 2023.
- Adjustment for the UIS population to include the acuity impacts due to further enrollment declines, primarily driven by the sunsetting of the temporary eligibility flexibilities in July 2025 and potential impact due to policy changes.
- For both SIS and UIS populations, the impact of population acuity adjustment specific to the expiring of waiver flexibilities and the UIS enrollment freeze was analyzed based on scenario testing where various scenarios of the acuity level of members who will leave the program were tested along with various scenarios of enrollment projections.

Program Change Adjustments

- LTC and hospice fee schedule changes.
- Ground Emergency Medical Transportation (GEMT) Quality Assurance Fee for private GEMT providers and Public Provider GEMT (PP-GEMT) add-on payment for public GEMT providers.
- Transitional Care Services: Effective January 1, 2024, Transitional Care Services must be provided to all members upon discharge from inpatient and LTC services.
- Children and Youth Behavioral Health Initiative: Adjustment accounting for impact of additional behavioral health services in schools for children and youth aged 0 – 25.
- Wellness Coach: Effective January 1, 2025, this policy change aims to provide wellness coaching benefits to all ages.
- UIS full-scope expansion enrollment freeze: Effective January 1, 2026, freezes new enrollment for full-scope expansion UIS members aged 19 and over.
- Part A Medicare Buy-In: Effective January 1, 2025, DHCS purchased Part A premiums for eligible partial Dual Medi-Cal members. The adjustment to 2026 rates includes considerations for both the first phase of the policy change (effective January 1, 2025) and the second phase (effective January 1, 2026).

Risk Adjustment Updates

- Chronic Illness and Disability Payment System and Medicaid Rx: An updated enrollment snapshot month of August 2025 was used with a November 2023 through October 2024 study period.
- Behavioral Health Treatment: Risk adjustment factors were updated to use the final CY 2026 enrollment projections.
- LTC: Risk adjustment process was updated to use an updated enrollment snapshot month of August 2025 and an updated period of April 2024 through December 2024.
- Community-Based Adult Services: Risk adjustment process was updated to use an updated enrollment snapshot month of August 2025.
- ECM: Risk adjustment factors were updated to reflect reported ECM enrollment through June 2025 and final CY 2026 enrollment projections.

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Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM)

- Updated FQHC APM PMPM add-on rate to reflect the revised FQHC APM PMPM rates for CY 2026 and assigned membership projections to applicable clinics.

Maternity Supplemental Payments

- Developed for the Child, Adult, ACA OE and Whole Child Model Categories of Aid in all rating regions for SIS and UIS members.
- UIS rates: CY 2026 UIS maternity supplemental payment rates are set to equal the SIS maternity supplemental payment rates.

Add-Ons

- Adverse Childhood Experiences, Developmental Screening, and Proposition 56 Family Planning.
- Pass-through payments for the Hospital Quality Assurance Fee.
- Managed Care Organization tax.

Fiscal Impact

In aggregate across all aid categories, the final CY 2026 draft rates are approximately 6.4% higher than the final CY 2025 rates. While the total enrollment is projected to be lower, DHCS anticipates a higher average acuity, which will drive additional expense on a PMPM basis. This results in an increase in CalOptima Health's CY 2026 rates.

The financials will reflect actual performance for the current fiscal year utilizing the final draft rates. Staff will include updated rates for the period of July 1, 2026, through December 31, 2026, in the CalOptima Health Fiscal Year 2026-27 Operating Budget.

Rationale for Recommendation

DHCS develops capitation rates according to base data reported by CalOptima Health through the rate development template process, adjusted for trends and program changes. Execution of the contract amendments will ensure revenues, expenses, and cash payment are consistent with the approved budget to support CalOptima Health operations.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachment

1. Attachment 1_Appendix Summary of Amendments to Primary and Secondary Agreements with DHCS

/s/ Michael Hunn *11/25/2025*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 6

The following is a summary of amendments to the Primary Agreement (23-30235) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Primary Agreement	Board Approval
Primary Agreement 23-30235 provides language and benefit changes effective January 1, 2024.	December 7, 2023
A-01 incorporates Calendar Year (CY) 2024 capitation rates.	March 7, 2024
A-02 incorporates language and benefit changes effective January 1, 2024.	August 1, 2024
A-03 extends the term of the Primary Agreement and Secondary Agreement (23 – 30267) (by default) to December 31, 2025.	November 7, 2024
A-04 incorporates updated final Calendar Year (CY) 2024 capitation rates.	April 3, 2025
A-05 incorporates final Calendar Year (CY) 2025 capitation rates and extends the Enhanced Care Management (ECM) risk corridor rating period through December 31, 2025.	April 3, 2025
A-06 incorporates language and benefit changes effective January 1, 2024.	June 5, 2025
A-07 incorporates language and benefit changes effective July 1, 2024.	August 7, 2025
A-08 incorporates language and benefit changes effective January 1, 2025, and extends the term of the Primary Agreement and Secondary Agreement (by default) to December 31, 2026.	November 6, 2025

The following is a summary of amendments to the Primary Agreement (08-85214) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010

Amendments to Primary Agreement	Board Approval
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012
A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014

Amendments to Primary Agreement	Board Approval
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015
A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017

Amendments to Primary Agreement	Board Approval
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A–45 incorporates the new requirements of the 2018 Final Rule Amendment, Behavioral Health Treatment (BHT) and State Fiscal Year (SFY) 2018 – 19 capitation rates	June 7, 2018 August 1, 2019 August 6, 2020
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020
A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021
A-52 incorporates Calendar Year (CY) 2021 base amendment contract language.	October 7, 2021
A-53 incorporates Calendar Year (CY) 2021 fall amendment contract language.	October 7, 2021
A-54 extends the Primary Agreement with DHCS to December 31, 2022.	October 7, 2021
A-55 incorporates full dual rates for Calendar Year (CY) 2022.	March 3, 2022
A-56 incorporates updated Bridge Period (July 1, 2019 – December 31, 2020) capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) and Unsatisfactory Immigration Status (UIS) members, and includes new corresponding rate tables that split each existing category into a SIS and UIS version.	October 1, 2020
A-57 incorporates Calendar Year (CY) 2022 risk mitigation language.	March 3, 2022
A-58 incorporates the COVID Vaccination Incentive Program.	March 3, 2022

Amendments to Primary Agreement	Board Approval
A-59 incorporates new Calendar Year (CY) 2022 capitation rates and benefit changes implemented in CY 2022	August 5, 2021 March 3, 2022 August 4, 2022
A-60 incorporates new benefits changes for Calendar Year (CY) 2022.	August 4, 2022
A-61 incorporates new benefit changes for Calendar Year (CY) 2022.	May 4, 2023
A-62 extends the Primary Agreement with DHCS to December 31, 2023.	May 5, 2022
A-63 incorporates new benefits changes for Calendar Year (CY) 2023.	February 2, 2023
A-64 incorporates updated Calendar Year (CY) 2021 capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members.	Not applicable due to non – substantive changes.
A-65 incorporates updated Calendar Year (CY) 2022 Public Health Emergency (PHE) capitation rates.	November 2, 2023
A-66 incorporates updated Calendar Year 2022 Capitation Payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members and includes new corresponding rate tables that split each existing category into a SIS version and UIS version.	Not applicable due to non – substantive changes.
A-67 incorporates Calendar Year (CY) 2023 capitation rates and new benefits for CY 2023.	December 7, 2023
A-68 incorporates revised Calendar Year (CY) 2022 CCI Full Dual capitation rates.	June 1, 2023
A-69 incorporates updated Calendar Year (CY) 2023 capitation rates.	October 3, 2024

The following is a summary of amendments to the Secondary Agreement (23-30267) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Secondary Agreement	Board Approval
Agreement 23 – 30267 covers specific state – supported services to CalOptima Health's members enrolled under CalOptima Health's Primary Agreement (23 – 30235).	December 7, 2023
A-01 incorporates Calendar Year (CY) 2024 capitation rates.	March 7, 2024
A-02 incorporates updated final Calendar Year (CY) 2024 capitation rates.	April 3, 2025
A-03 incorporates final Calendar Year (CY) 2025 capitation rates.	April 3, 2025
A-04 incorporates changes to the Unsatisfactory Immigration Status (UIS) Member definition and Change Order Process.	November 6, 2025

The following is a summary of amendments to the Secondary Agreement (08-85221) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010

A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-09 incorporates updated Calendar Year (CY) 2022 Public Health Emergency (PHE) capitation rates.	November 2, 2023
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021

The following is a summary of amendments to the Secondary Agreement (22-20494) approved by the CalOptima Health Board of Directors (Board) to date:

Agreement 22-20494 incorporates both Hyde services ("Private Services") and the new Unsatisfactory Immigration Status members from January 1, 2023 to December 31, 2023.	December 1, 2022
A-01 incorporates rates for CY 2023 for Hyde services (now referred to as "Private Services") and the new Unsatisfactory Immigration Status (UIS) members.	December 1, 2022
A-02 incorporates updated Calendar Year (CY) 2023 capitation rates.	October 3, 2024

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2022.	June 3, 2021
A-06 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	May 5, 2022
A-07 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	October 6, 2022
A-08 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	Not applicable due to non – substantive changes.
A-09 extends Agreement 16 – 93274 with DHCS to December 31, 2024.	May 4, 2023
A-10 extends Agreement 16 – 93274 with DHCS to December 31, 2025.	May 2, 2024

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

The following is a summary of amendments to CalOptima Health's Agreement for Disclosure and Use of DHCS Data (2023 Post – Expiration Data Use Agreement (DUA)) and 2024 Operational Readiness (OR) DUA.

Amendments to Data Use Agreement	Board Approval
CY 2023 Data Use Agreement (DUA) allows for the exchange of information between DHCS and CalOptima Health after the current contract expires on December 31, 2023.	November 2, 2023
CY 2024 Operational Readiness (OR) DUA allows DHCS to initiate and execute the necessary data releases ahead of January 1, 2024 for DHCS to share necessary data with CalOptima Health.	November 2, 2023

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 4, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

7. Ratify Actions Related to Federal Shutdown Response Supplemental Food Support for CalOptima Health Members

Contacts

Dr. Kelly Bruno-Nelson, Executive Director of Medi-Cal and CalAIM, (657) 550-4741
Veronica Carpenter, Chief Administrative Officer, (657) 650-9531

Recommended Actions

Ratify a reallocation of up to $1.5 million from the grant agreements with two Orange County food bank distribution hubs to fully fund the initiative to provide one $25 nonmonetary flex card to individual Medi-Cal members who are enrolled in the Supplemental Nutrition Assistance Program.

Background/Discussion

CalFresh, federally known as the Supplemental Nutrition Assistance Program (SNAP), helps low-income residents buy healthy food. More than 310,000 Orange County (County) residents, including 94,000 adults who are 60 years or older and 91,000 children, receive CalFresh. Due to the federal government shutdown, CalFresh benefits were delayed in November, contributing to food insecurity across the county.

On November 6, 2025, the CalOptima Health Board of Directors (Board) unanimously supported an appropriation of up to $8.0 million from existing reserves to fund grant agreements with Second Harvest Food Bank of Orange County (Second Harvest) and Community Action Partnership Orange County (CAPOC) of $1.5 million each, and $5.0 million to provide one $25 nonmonetary flex card to each individual Medi-Cal member who is enrolled in SNAP during the federal shutdown period.

Grant Agreements with Food Banks

With Board approval, CalOptima Health staff proceeded with prompt development and execution of grant agreements, including scopes of work, with Second Harvest and CAPOC. These grant agreements became effective on November 1, 2025, and CalOptima Health provided a combined $1.5 million funding to Second Harvest and CAPOC.

In accordance with the terms of the grant agreements, and following the conclusion of the federal government shutdown on November 12, 2025, the grant agreements have now been terminated. As a result, there is a remaining unspent balance of $1.5 million.

Member Flex Cards

Staff also worked with the County's Social Services Agency (SSA) on a method to identify CalOptima Health members who are also CalFresh beneficiaries. On November 7, 2025, SSA provided CalOptima Health with a data file, and CalOptima staff was able to identify nearly 225,000 unduplicated members who did not receive their SNAP benefits on time. This group represents over 25% of CalOptima Health's total membership.

Back to Agenda

To facilitate the distribution of grocery flex cards to Medi-Cal members who are also enrolled in SNAP, CalOptima Health has worked with Soda Health—the current OneCare flex card vendor—to develop a scope of work and contract amendment. By consolidating benefits onto a single card per family, approximately 154,000 flex cards were issued. There is an estimated add-on administrative cost per flex card issued to an eligible family of $5.50. It is approximately 13.2% of the total program expense. This administrative cost includes: (1) a per member per month card maintenance fee, which allows adequate time for members to use any remaining balances through February 28, 2026; and (2) a card kit, which includes postage and the issuance of a reloadable card that contains the $25 benefit. This methodology provides CalOptima Health with a vehicle to distribute future non-monetary rewards by reloading funds to these flex cards.

Given the urgency of this initiative—aimed at supporting members who depend on SNAP benefits for themselves and their households—additional administrative costs have been incurred to ensure timely distribution. These costs include the production of card carriers, configuration of the user interface for card activation and balance tracking, and administrative fees to support the maintenance of the cards until their expiration date, February 28, 2026.

Staff is seeking Board ratification to reallocate $1.5 million that was allocated for the grant agreements with the Second Harvest and CAPOC to provide additional support for the initiative to provide one $25 nonmonetary flex card to individual Medi-Cal members who are enrolled in SNAP.

Fiscal Impact
There is no additional fiscal impact. A reallocation in an amount up to $1.5 million remaining from the terminated grant agreements with two Orange County food banks that was approved by the Board on November 6, 2025, will support the expenses related to providing one $25 nonmonetary flex card to individual Medi-Cal members who are enrolled in SNAP.

Rationale for Recommendation
This ratification of up to $1.5 million will support the expenses related to providing nonmonetary flex cards to Medi-Cal members who are enrolled in SNAP.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Previous Board Action, dated November 6, 2025, "Approve Actions Related to Federal Shutdown Response Supplemental Food Support for CalOptima Health Members"

/s/ Michael Hunn *11/26/2025*
Authorized Signature **Date**

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Attachment to the December 4, 2025, Board of Directors Meeting – Agenda Item 7

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Community Action Partnership of Orange County	11870 Monarch Street	Garden Grove	CA	92841
Second Harvest Food Bank of Orange County, Inc.	8014 Marine Way	Irvine	CA	92618

CalOptima Health Board Action Agenda Referral

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

Report Item

13. Approve Actions Related to Federal Shutdown Response Supplemental Food Support for CalOptima Health Members

Contacts

Dr. Kelly Bruno-Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741
Veronica Carpenter, Chief Administrative Officer, (657) 650-9531

Recommended Actions

1. Appropriate and allocate up to ~~$7.0~~ $8 million from existing reserves to fund supplemental food support for Medi-Cal members during the federal shutdown as follows:
    a. Up to ~~$2.0~~ $3 million to fund grant agreements with two Orange County food bank distribution hubs; and
    b. Up to $5.0 million to provide one $25 nonmonetary flex card to individual Medi-Cal members who are enrolled in the Supplemental Nutrition Assistance Program.
2. Authorize the Chief Executive Officer or designee to execute and administer grant agreements and release award payments up to ~~$1.0~~ $1.5 million each to Second Harvest Food Bank of Orange County and Community Action Partnership Orange County.
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.
4. Authorize CalOptima Health staff to work with the Social Services Agency of Orange County to determine a list of CalOptima Health members who are also receiving Supplemental Nutrition Assistance Program benefits, who will be eligible for a $25 nonmonetary flex card from CalOptima Health as additional food support while these benefits are suspended.
5. Authorize the Chief Executive Officer or designee to execute a contract amendment with Soda Health, the flex card vendor, to update the scope of work and payment terms for the administration and distribution of flex cards to Medi-Cal members eligible to receive the supplemental food support.

Rev. 11/6/25

Background

CalFresh, federally known as the Supplemental Nutrition Assistance Program (or SNAP), helps low-income residents buy healthy food. More than 310,000 Orange County residents, including 94,000 older adults who are 60 years or older and 91,000 children, receive CalFresh. Due to the ongoing federal government shutdown, CalFresh benefits will be delayed in November, contributing to food insecurity across the county. The federal government issued guidance on Friday, October 24, 2025, that SNAP benefits will be suspended until the shutdown is resolved.

Approximately 92% of CalFresh recipients in California also have Medi-Cal coverage. Staff estimates that in Orange County, the majority (approximately 225,000) of the 310,000 individuals, including seniors and children, receiving CalFresh are also CalOptima Health members. To prevent CalOptima Health's members from experiencing additional food insecurity, and given these exceptional

circumstances, CalOptima Health is seeking to partner with Second Harvest Food Bank of Orange County (Second Harvest) and Community Action Partnership Orange County (CAPOC), the two main food distributors in Orange County, to ensure an adequate supply of food is available.

In addition to direct food distribution, CalOptima Health is also planning to distribute grocery flex cards to dual Medi-Cal/SNAP members and OneCare/SNAP members who have had their SNAP benefits halted. This distribution of supplemental food support will further combat hunger and malnutrition among CalOptima Health membership during a national crisis.

Discussion

CalOptima Health intends to work with the two primary distributors to food pantries and food banks across Orange County. Together, Second Harvest and CAPOC annually distribute 65 million pounds of food through their combined network of nearly 600 community partner locations. Their expansive list of partners include houses of worship, schools, after-school programs, senior centers, shelters for the unhoused, soup kitchens, and transitional housing facilities, resulting in hundreds of locations throughout the county.

With the decrease in supplemental food benefits, CalOptima Health plans to work with Second Harvest and CAPOC to guarantee an increased availability of food at distributions sites throughout Orange County in support of neighbors who are at risk for experiencing hunger. CalOptima Health staff recommends a grant award of up to ~~$1,000,000~~ $1,500,000 to each organization (totaling ~~$2,000,000~~ $3,000,000) for food provision and expanded distribution hours at several sites in Orange County, particularly in districts that have a high percentage of residents with CalOptima Health coverage. These funds would support the organizations in expanded distribution and access to food through February, should SNAP benefits continue to be delayed through that time. *Rev. 11/6/25*

With CalOptima Health Board of Directors (Board) approval, staff would like to proceed with prompt development and execution of grant agreements, including scopes of work, with Second Harvest and CAPOC. These grant agreements will be in effect beginning November 1, 2025, and will continue on a month-to-month basis. The grant agreements would end either February 28, 2026, or upon the end of the federal shutdown, whichever is sooner. Staff will provide oversight of the grants pursuant to CalOptima Health Policy AA.1400: Grant Management, and will return to the Board to provide updates on the status of these grants at future meetings.

To distribute grocery flex cards to Medi-Cal members who are enrolled in SNAP, CalOptima Health will engage in two simultaneous efforts with Board approval. First, CalOptima Health staff will work with the Social Services Agency of Orange County to determine a list of CalOptima Health members receiving SNAP benefits who will be deemed eligible for a flex card. Second, staff will work with Soda Health, the OneCare flex card vendor, to develop a scope of work and contract amendment to distribute flex cards to eligible members. Once these efforts are complete, the flex card vendor will distribute one $25 nonmonetary card to each eligible member. Staff are requesting up to $5,000,000 to cover this cost.

This distribution of supplemental food support will combat hunger and malnutrition among CalOptima Health membership during a national crisis. Members will be notified of these supplemental food resources through direct mailing of the flex cards, social media outreach, e-newsletter distributions, and local network sharing (*e.g.*, 211OC and other organizations helping to communicate the information).

Fiscal Impact

An appropriation of up to ~~$7.0~~ $8 million from existing reserves will fund the grant agreements with Second Harvest and CAPOC, and the provision of one $25 nonmonetary flex card to each individual Medi-Cal member who is enrolled in SNAP during the federal shutdown period.

Rev. 11/6/25

Rationale for Recommendation

CalOptima is working to reduce the risk of malnutrition and hunger to members during this national crisis.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *10/31/2025*
Authorized Signature **Date**

Attachment to the November 6, 2025, Board of Directors Meeting – Agenda #13

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Community Action Partnership of Orange County	11870 Monarch Street	Garden Grove	CA	92841
Second Harvest Food Bank of Orange County, Inc.	8014 Marine Way	Irvine	CA	92618

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 4, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
8. Receive and File Closed and Open Board Ad Hoc Committees

Contact
Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Actions
Receive and File Fiscal Year Closed Board Ad Hoc Committee List and Open Board Ad Hoc Committee List.

Background
The Ralph M. Brown Act (Brown Act) requires open and public meetings by legislative bodies of local agencies when conducting the public's business. Under the Brown Act, advisory committees composed solely of the members of the legislative body that are less than a quorum of the legislative body are not legislative bodies where those committees are charged with specific tasks for a limited period of time.

On June 2, 2022, the CalOptima Health Board of Directors (Board) adopted a resolution outlining the process for dissolving closed Board ad hoc committees and reporting out of new or current Board ad hoc committees. That process is outlined in Attachment 1.

The Clerk of the Board is charged with maintaining the list of ad hoc committees and bringing the list of ad hoc committees to the Board for review on an annual basis. Note that this process was delayed until a Chair of the CalOptima Health Board was officially elected, which occurred at the December 7, 2023, meeting.

On February 1, 2024, the Board received and filed a Closed Board Ad Hoc list and an Open Board Ad Hoc list.

Discussion

When necessary, the Chair of the Board assigns members to serve as an ad hoc committee to study an item or accomplish a specific task. Accordingly, the Board's ad hoc committees serve for a limited term and are not standing committees. Ad hoc committees serve the Board and the public by allowing members of the Board to efficiently investigate and collaborate on an item of concern consistent with the Brown Act.

Attachment #3 contains a redlined list of Board ad hoc committees that staff recommends be filed and closed out as of December 4, 2025.

Fiscal Impact
There is no fiscal impact.

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Rationale for Recommendation

This item officially reports out the closed Board ad hoc committees and new or current board ad hoc committees in a manner consistent with CalOptima Health's established policy.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Previous Board Action dated June 2, 2022, Receive and File Open and Closed Board Ad Hoc Committees
2. Previous Board Action dated February 1, 2024, Receive and File Closed and Open Board Ad Hoc Committees
3. 2024-2025 –Board Ad Hoc List Redlined

/s/ Michael Hunn *11/25/2025*
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

Consent Calendar

6. Adopt Resolution Dissolving Existing Board Ad Hoc Committees and Creating New Board Ad Hoc Committees, and Establish a Policy for Administration of Ad Hoc Committees

Contact

Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Actions

Adopt resolution to:

1. Dissolve existing Board Ad Hoc Committees;
2. Create new Ad Hoc Board Committees; and
3. Establish a policy for the administration of future ad hoc committees.

Background

The Ralph M. Brown Act (Brown Act) requires open and public meetings by "legislative bodies" of local agencies when conducting the public's business. Under the Brown Act, advisory committees composed solely of the members of the legislative body that are less than a quorum of the legislative body are not "legislative bodies," where those committees are charged with specific tasks for a limited period of time.

When necessary, the Chair of the CalOptima Board of Directors (Board) assigns members to serve as an ad hoc committee to study an item or accomplish a specific task. Accordingly, the Board's ad hoc committees serve for a limited term and are not standing committees. Ad hoc committees serve the Board and the public by allowing members of the Board to efficiently investigate and collaborate on an item of concern consistent with the Brown Act.

Discussion

For administrative clarity, Staff recommends that the Board dissolve all existing ad hoc committees and create the new ad hoc committees listed in the attachment to this proposed resolution, which includes the following information:

- Name of the ad hoc committee;
- Committee's membership;
- Limited scope of the ad hoc committee's task; and
- Date that the ad hoc committee will dissolve.

The proposed resolution establishes the policy for creating and dissolving ad hoc committees. Under the proposed policy, the Board Chair may create an ad hoc committee to serve as an advisory committee on a specific item for a limited period of time. The Chair will identify the committee's membership, scope of work, and date of dissolution. The Clerk of the Board will be charged with maintaining the list and bringing the list and ad hoc committee policy to the Board for review on an annual basis.

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Fiscal Impact
There is no financial impact.

Rationale for Recommendation
This item will provide clarity on CalOptima's use of ad hoc committees in a manner consistent with the Brown Act.

Concurrence
Troy R. Sabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed Resolution
2. Proposed Ad Hoc List

Board Action(s)
None

/s/ Michael Hunn *05/27/2022*
Authorized Signature **Date**

RESOLUTION NO. 22-0602-03

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

RESOLUTION FOR CALOPTIMA BOARD AD HOC COMMITTEES

WHEREAS, the Ralph M. Brown Act is California's "Open Meetings" or "Sunshine" law that requires open and public meetings by legislative bodies of local agencies when conducting the public's business;

WHEREAS, the Brown Act provides that, unless certain conditions are satisfied, a legislative body is prohibited from discussing or acting on any item not appearing on the posted agenda of a public meeting;

WHEREAS, under the Brown Act, advisory committees composed solely of members of the legislative body that are less than a quorum of the legislative body are not "legislative bodies," where those committees do not have a continuing subject matter jurisdiction and do not have a meeting schedule fixed by formal action of the legislative body;

WHEREAS, ad hoc committees serve for a limited period of time on discrete items or tasks as directed by the Chair of the Board;

WHEREAS, advisory committees shall be comprised of no more than four members of the CalOptima Board of Directors and assist the Board and the public it serves in efficiently investigating and collaborating on items of concern; and

WHEREAS, to ensure Brown Act compliance and for administrative clarity, the Board should identify which ad hoc committees are currently active and adopt a policy for the administration of ad hoc committees.

NOW, THEREFORE, BE IT RESOLVED:

1. That the CalOptima Board of Directors hereby:
    a. Dissolves all existing ad hoc committees; and
    b. Creates the ad hoc committees listed in Attachment 2, subject to the membership, scope of work, and dissolution dates listed in Attachment 2.

2. That the Board of Directors hereby adopts the following policy for the administration of ad hoc committees:
    a. At any meeting of the CalOptima Board of Directors, the Chair may create ad hoc committees composed of no more than four Board members to serve as an advisory committee on a specific item for a limited period of time. Where the Chair creates an ad hoc committee, he or she will identify the committee's membership, scope of work, work product, and date of dissolution.

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b. The Clerk of the Board shall maintain a list of active ad hoc committees.
c. On an annual basis, the Clerk of the Board shall place on the Board's meeting agenda a review of the ad hoc committee list and policy.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of June 2022.

AYES: _____

NOES: _____

ABSENT: _____

ABSTAIN: _____

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Andrew Do, Chair, CalOptima Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

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CalOptima Board Ad Hoc Committees –
FY 2022 - 2023

Ad Hoc Committee	Ad Hoc Members	Date Established	Scope of Work	Work Product	Dissolution Date
Homeless Health Initiatives Ad Hoc	Andrew Do Doug Chaffee Clayton Corwin Nancy Shivers	6/2/2022	Review the homeless health initiatives consistent with street medicine and the Homeless Health Incentive Program.	Oral Report to the Board.	To be closed at the end of FY 2022-2023.
Audit Ad Hoc	Isabel Becerra Clayton Corwin Clayton Chau Scott Schoeffel	6/2/2022	To review prepared responses, findings, results and corrective action plans issues by CMS and DHCS.	Oral Report to the Board.	To be closed upon receipt of final report from CMS and DHCS or no later than the end of FY 2022-2023.
Legislative Ad Hoc/Ad Hoc will be responsible for the initial review of legislative bills that are in alignment with the Board-approved legislative platform.	Andrew Do Clayton Corwin Scott Schoeffel Clayton Chau	6/2/2022	To review legislative proposals within the jurisdiction of the legislative platform.	Report provided in the CEO Direct Reports.	To be closed upon no later than the end of FY 2022-2023.
Strategic Planning Ad Hoc/ Ad Hoc will review CalOptima's strategic planning and growth.	Andrew Do Blair Contratto Clayton Corwin Scott Schoeffel	6/2/2022	Provide regular input and feedback on the strategic planning effort.	Oral Report to the Board.	To be closed at the end of FY 2022-2023.

CalOptima Health Board Action Agenda Referral

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

Consent Calendar
13. Receive and File Closed and Open Board Ad Hoc Committees

Contact
Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Actions
Receive and File Fiscal Year (FY) 2022-2023 Closed Board Ad Hoc Committee List and FY 2023-2024 Open Board Ad Hoc Committee List.

Background
The Ralph M. Brown Act (Brown Act) requires open and public meetings by legislative bodies of local agencies when conducting the public's business. Under the Brown Act, advisory committees composed solely of the members of the legislative body that are less than a quorum of the legislative body are not legislative bodies, where those committees are charged with specific tasks for a limited period of time.

When necessary, the Chair of the CalOptima Health Board of Directors (Board) assigns members to serve as an ad hoc committee to study an item or accomplish a specific task. Accordingly, the Board's ad hoc committees serve for a limited term and are not standing committees. Ad hoc committees serve the Board and the public by allowing members of the Board to efficiently investigate and collaborate on an item of concern consistent with the Brown Act.

Discussion
On June 2, 2022, the CalOptima Health Board adopted a resolution outlining the process for dissolving closed Board Ad Hoc Committees and reporting out of new or current Board Ad Hoc Committees. See Attachment 1.

The resolution adopted on June 2, 2022, established the policy for creating and dissolving ad hoc committees. Under the policy, the Board Chair may create ad hoc committees to serve as advisory committees on specific items for a limited period of time. The Chair identifies the committees' memberships, scopes of work, and dates of dissolution. The Clerk of the Board is charged with maintaining the list and bringing the list of ad hoc committees to the Board for review on an annual basis. Note that this agenda item was delayed until a Chair of the CalOptima Health Board was officially elected, which occurred at the December 7, 2023, meeting.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
This item officially reports out the closed Board Ad Hoc Committees and new or current Board Ad Hoc Committees in a manner consistent with established policy.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Previous Board Action dated June 2, 2022, Receive and File Open and Closed Board Ad Hoc Committees
2. FY 2022-2023 - Closed Board Ad Hoc List
3. FY 2023-2024 – Open Board Ad Hoc List

/s/ Michael Hunn *01/25/2024*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Adopt Resolution Dissolving Existing Board Ad Hoc Committees and Creating New Board Ad Hoc Committees, and Establish a Policy for Administration of Ad Hoc Committees

Contact

Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Actions

Adopt resolution to:

1. Dissolve existing Board Ad Hoc Committees;
2. Create new Ad Hoc Board Committees; and
3. Establish a policy for the administration of future ad hoc committees.

Background

The Ralph M. Brown Act (Brown Act) requires open and public meetings by "legislative bodies" of local agencies when conducting the public's business. Under the Brown Act, advisory committees composed solely of the members of the legislative body that are less than a quorum of the legislative body are not "legislative bodies," where those committees are charged with specific tasks for a limited period of time.

When necessary, the Chair of the CalOptima Board of Directors (Board) assigns members to serve as an ad hoc committee to study an item or accomplish a specific task. Accordingly, the Board's ad hoc committees serve for a limited term and are not standing committees. Ad hoc committees serve the Board and the public by allowing members of the Board to efficiently investigate and collaborate on an item of concern consistent with the Brown Act.

Discussion

For administrative clarity, Staff recommends that the Board dissolve all existing ad hoc committees and create the new ad hoc committees listed in the attachment to this proposed resolution, which includes the following information:

- Name of the ad hoc committee;
- Committee's membership;
- Limited scope of the ad hoc committee's task; and
- Date that the ad hoc committee will dissolve.

The proposed resolution establishes the policy for creating and dissolving ad hoc committees. Under the proposed policy, the Board Chair may create an ad hoc committee to serve as an advisory committee on a specific item for a limited period of time. The Chair will identify the committee's membership, scope of work, and date of dissolution. The Clerk of the Board will be charged with maintaining the list and bringing the list and ad hoc committee policy to the Board for review on an annual basis.

Fiscal Impact
There is no financial impact.

Rationale for Recommendation
This item will provide clarity on CalOptima's use of ad hoc committees in a manner consistent with the Brown Act.

Concurrence
Troy R. Sabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed Resolution
2. Proposed Ad Hoc List

Board Action(s)
None

/s/ Michael Hunn *05/27/2022*
Authorized Signature **Date**

RESOLUTION NO. 22-0602-03

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

RESOLUTION FOR CALOPTIMA BOARD AD HOC COMMITTEES

WHEREAS, the Ralph M. Brown Act is California's "Open Meetings" or "Sunshine" law that requires open and public meetings by legislative bodies of local agencies when conducting the public's business;

WHEREAS, the Brown Act provides that, unless certain conditions are satisfied, a legislative body is prohibited from discussing or acting on any item not appearing on the posted agenda of a public meeting;

WHEREAS, under the Brown Act, advisory committees composed solely of members of the legislative body that are less than a quorum of the legislative body are not "legislative bodies," where those committees do not have a continuing subject matter jurisdiction and do not have a meeting schedule fixed by formal action of the legislative body;

WHEREAS, ad hoc committees serve for a limited period of time on discrete items or tasks as directed by the Chair of the Board;

WHEREAS, advisory committees shall be comprised of no more than four members of the CalOptima Board of Directors and assist the Board and the public it serves in efficiently investigating and collaborating on items of concern; and

WHEREAS, to ensure Brown Act compliance and for administrative clarity, the Board should identify which ad hoc committees are currently active and adopt a policy for the administration of ad hoc committees.

NOW, THEREFORE, BE IT RESOLVED:

1. That the CalOptima Board of Directors hereby:
    a. Dissolves all existing ad hoc committees; and
    b. Creates the ad hoc committees listed in Attachment 2, subject to the membership, scope of work, and dissolution dates listed in Attachment 2.

2. That the Board of Directors hereby adopts the following policy for the administration of ad hoc committees:
    a. At any meeting of the CalOptima Board of Directors, the Chair may create ad hoc committees composed of no more than four Board members to serve as an advisory committee on a specific item for a limited period of time. Where the Chair creates an ad hoc committee, he or she will identify the committee's membership, scope of work, work product, and date of dissolution.

b. The Clerk of the Board shall maintain a list of active ad hoc committees.
c. On an annual basis, the Clerk of the Board shall place on the Board's meeting agenda a review of the ad hoc committee list and policy.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of June 2022.

AYES: _____

NOES: _____

ABSENT: _____

ABSTAIN: _____

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Andrew Do, Chair, CalOptima Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

CalOptima Board Ad Hoc Committees –
FY 2022 - 2023

Ad Hoc Committee	Ad Hoc Members	Date Established	Scope of Work	Work Product	Dissolution Date
Homeless Health Initiatives Ad Hoc	Andrew Do Doug Chaffee Clayton Corwin Nancy Shivers	6/2/2022	Review the homeless health initiatives consistent with street medicine and the Homeless Health Incentive Program.	Oral Report to the Board.	To be closed at the end of FY 2022-2023.
Audit Ad Hoc	Isabel Becerra Clayton Corwin Clayton Chau Scott Schoeffel	6/2/2022	To review prepared responses, findings, results and corrective action plans issues by CMS and DHCS.	Oral Report to the Board.	To be closed upon receipt of final report from CMS and DHCS or no later than the end of FY 2022-2023.
Legislative Ad Hoc/Ad Hoc will be responsible for the initial review of legislative bills that are in alignment with the Board-approved legislative platform.	Andrew Do Clayton Corwin Scott Schoeffel Clayton Chau	6/2/2022	To review legislative proposals within the jurisdiction of the legislative platform.	Report provided in the CEO Direct Reports.	To be closed upon no later than the end of FY 2022-2023.
Strategic Planning Ad Hoc/ Ad Hoc will review CalOptima's strategic planning and growth.	Andrew Do Blair Contratto Clayton Corwin Scott Schoeffel	6/2/2022	Provide regular input and feedback on the strategic planning effort.	Oral Report to the Board.	To be closed at the end of FY 2022-2023.

CalOptima Health Board Ad Hoc Committees

FY 2022 – 2023

CLOSED

Ad Hoc Committee	Ad Hoc Members	Date Established	Scope of Work	Work Product	Dissolution Date
Homeless Health Initiatives Ad Hoc	Andrew Do Doug Chaffee Clayton Corwin Nancy Shivers	6/2/2022	Review the homeless health initiatives consistent with street medicine and the Homeless Health Incentive Program.	Oral Report to the Board.	12/8/2023
Audit Ad Hoc	Isabel Becerra Clayton Corwin Clayton Chau Scott Schoeffel	6/2/2022	To review prepared responses, findings, results and corrective action plans issues by CMS and DHCS.	Oral Report to the Board.	12/8/2023
Legislative Ad Hoc/Ad Hoc will be responsible for the initial review of legislative bills that are in alignment with the Board-approved legislative platform.	Andrew Do Clayton Corwin Scott Schoeffel Clayton Chau	6/2/2022	To review legislative proposals within the jurisdiction of the legislative platform.	Report provided in the CEO Direct Reports.	12/8/2023
Strategic Planning Ad Hoc/ Ad Hoc will review CalOptima's strategic planning and growth.	Andrew Do Blair Contratto Clayton Corwin Scott Schoeffel	6/2/2022	Provide regular input and feedback on the strategic planning effort.	Oral Report to the Board.	12/8/2023

CalOptima Health Board Ad Hoc Committees
FY 2023 - 2024

Ad Hoc Committee	Ad Hoc Members	Date Established	Scope of Work	Work Product	Dissolution Date
1090 Investigation Ad Hoc	Clayton Corwin Blair Contratto	05/04/2023	Looking into the 1090 investigation brought up in the California State Audit Report to see if there was any wrongdoing by the CalOptima Health Board	Oral report back to the Board	TBD
Governance Ad Hoc	Blair Contratto, Ad Hoc Chair Isabel Becerra Vicente Sarmiento	09/08/2023	Responsible for drafting initial Board Rules of Procedures and outline a more formal process for election of officers and other Board processes	Oral and written Board processes Board approved policy for Election of Officers 11/2/23 Board approved using Rosenberg's Rules of Procedure for conducting CalOptima Health Board of Directors meetings on 12/7/2023	TBD
Strategic Planning Ad Hoc	Clayton Corwin Isabel Becerra Jose Mayorga, M.D. Doug Chaffee	01/25/2024	Responsible for providing regular feedback and guidance on CalOptima Health's Strategic Planning efforts.	Oral report back to the Board	TBD

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CalOptima Health Board Ad Hoc Committees
2024-2025
OPEN

Ad Hoc Committee	Ad Hoc Members	Date Established	Scope of Work	Work Product	Dissolution Date
Governance Ad Hoc	Blair Contratto, Ad Hoc Chair Isabel Becerra Vicente Sarmiento	09/08/2023	Responsible for drafting initial Board Rules of Procedures and outline a more formal process for election of officers and other Board processes	Oral and written Board processes Board approved policy for Election of Officers 11/2/23 Board approved using Rosenberg's Rules of Procedure for conducting CalOptima Health Board of Directors meetings on 12/7/2023 Ad hoc met on 3/14/2024 Oral and written Board processes Board approved policy for Election of Officers 11/2/23 Board approved using Rosenberg's Rules of Procedure for conducting CalOptima Health Board of Directors meetings on	~~TBD~~12/4/2025 Ad Hoc has completed Board Rules and governance policies.

				12/7/2023 Ad hoc met on 3/14/2024 Ad Hoc Chair reported at the 4/4/2024 Board meeting that the Governance ad hoc has identified several items for consideration, which included possibly staggering the terms of office for Board members and identifying the best time to conduct the Election of Officers for the Board Chair and Board Vice Chair. Director Contratto noted that when the Governance Ad Hoc Committee meets in April, it will review and finalize the recommendations and bring those recommendations back to the Board for consideration. Director Contratto also noted that the ad hoc committee discussed	

				one of the recommendations from the California State Audit report, which was the CEO selection process. She added that the Governance Ad Hoc Committee will be recommending that a separate ad hoc committee be created to determine the process for CEO succession planning, recruitment and selection process.	
Strategy Ad Hoc/ Strategic Planning Ad Hoc	Clayton Corwin ~~Blair Contratto~~ Jose Mayorga Doug Chaffee Isabel Becerra	01/25/2024	Responsible for providing regular feedback and guidance on CalOptima Health's Strategic Planning efforts.	Oral report back to the Board Met on 2/20/2024 -Corwin -Becerra -Mayorga -Chaffee Met on 4/29/2024 -Corwin -Chaffee -Becerra -Mayorga	~~TBD~~ 12/4/2025 CalOptima Health's Fiscal Year 2025-2027 Strategic Plan was approved and adopted by the Board at the February 2025 Board meeting. Staff regulary provides quarterly reports to the Board of Directors.-

Executive Compensation and Performance Evaluation Ad Hoc	Isabel Becerra, Ad Hoc Chair, Blair Contratto Vicente Sarmiento	06/06/2024	Focus on further analysis and evaluation of appropriate levels of executive compensation	Oral report back to the Board	~~TBD~~12/4/2025 At this time, per the California State Audit, salaries and compensation are commensurate with public health plans across the state. If needed in the future, the Board will convene an ad hoc at the appropriate time to analyze and make recommendations.

CalOptima Health Board Ad Hoc Committees
2024-2025
OPEN

Ad Hoc Committee	Ad Hoc Members	Date Established	Scope of Work	Work Product	Dissolution Date
Legal Ad Hoc	Norma García Guillén, Ad Hoc Chair Maura Byron Brian Helleland	9/5/2024	Responsible for reviewing Legal Issues in conjunction with Outside Legal Counsel, Kennaday Leavitt	2/6/2025 Chair of Legal Ad Hoc, Director Garcia Guillen noted during the approval of Agenda Item 8, that the Legal Ad Hoc recommends that the Board create a Grant Oversight Committee Ad Hoc, which could turn into a standing committee in the future. The Board agreed to the creation of the recommended ad hoc and members would be appointed at a later date. 3/6/2025: Director Garcia Guillen, Chair of the Board's Legal Ad Hoc Committee, serving along with Director Byron and Director Helleland, noted that the ad hoc committee has been meeting at least twice a month for the last five months to ensure that the external auditor reviewing the procurement and grants from CalOptima Health has been diligent, transparent, and expedient.	TBD

				The Legal Ad Hoc Committee expects to have a report within a month or so, and at that time, the ad hoc committee expects to return to the Board with further details. Met on 9/13/2024 Met on 9/27/2024 Met on 10/11/2024 Met on 10/18/2024 Met on 10/25/2024 Met on 11/1/2024 Met on 11/15/2024 Met on 11/22/2024 Met on 12/13/2024 Mtg cancelled on 12/20/2024 Mtg cancelled on 12/27/2024 Met on 1/3/2025 Met on 1/10/2025 Met on 1/17/2025 Met on 1/31/2025 Met on 2/14/2025 Met on 2/21/2025 Met on 2/28/2025 Met on 3/6/2025 Met on 3/14/2025 Met on 3/28/2025 Met on 4/3/2025 Met on 4/11/2025 Met on 4/18/2025	

				Met on 4/25/2025 Met on 5/9/2025 Met on 5/13/2025 Met on 5/16/2025 Met on 5/23/2025 Met on 5/30/2025 Met on 6/20/2025 Met on 6/27/2025 Met on 7/11/2025 Met on 7/25/2025 Met on 8/1/2025 Met on 8/15/2025 Met on 8/22/2025	
Legislative Ad Hoc	Isabel Becerra Vicente Sarmiento Norma Garcia Guillen	3/6/2025	Was established to address legislative and advocacy issues	5/1/2025 -- Vice Chair Sarmiento provided an update on the Legislative Ad Hoc Committee, which the Board established to address legislative and advocacy issues. He noted that the Legislative Ad Hoc Committee, consisting of himself, Chair Becerra, and Director Garcia Guillen has met twice since its creation in March. Vice Chair Sarmiento reported that the ad hoc committee has been receiving timely updates from Clear	~~TBD~~9/4/2025 Recommendation from the ad hoc to create a standing Legislative Committee of the Board as reported out on September 4, 2025.

				Advocacy, CalOptima Health's state lobbyist, and Chamber Hill Strategies, its federal lobbyist. As both the state and federal administrations continue budget negotiations with the state legislature and Congress, CalOptima Health is navigating a highly dynamic and fluid environment. Vice Chair Sarmiento noted that the current environment is unsettling due to the uncertainty and unpredictability. The ad hoc committee recommended and supported CalOptima Health by sending a joint letter with key Orange County safety net partners to the Orange County federal delegation expressing strong opposition to any proposed cuts to Medicaid. In addition, the ad hoc committee is considering recommending sending a	

				similar letter to the DHCS. Met on 3/24/2025 Met on 4/21/2025 Met on 5/19/2025 Met on 6/17/2025 Meeting cancelled on 7/28/2025 Met on 8/25/2025	
Grants Management Ad Hoc	Maura Byron Catherine Green, R.N. Brian Helleland to serve as Alternate	3/6/2025	Recommendation made and approved on 8/7/2025	8/7/2025 Director Byron provided an update on the Grants Management Committee. Met on 3/28/2025 Met on 4/11/2025 Met on 4/25/2025 Met on 5/9/2025 Met on 5/23/2025 Met on 6/10/2025 Met on 6/30/2025 Met on 7/18/2025 Met on 7/29/2025 Met on 8/14/2025 Met on 8/29/2025 Met on 9/26/2025 Met on 10/14/2025 Met on 10/29/2025 Met on 11/18/2025	~~TBD~~12/4/2025 The grant management ad hoc committee successfully completed ~~our~~the stated scope to guide the establishment of: ~~a~~ 1)~~g~~Governance structure~~,~~ 2) ~~p~~Policies and procedures~~, and~~ 3) S~~s~~tandardized tools for grant management.

Policy and Budget Assessment Ad Hoc	TBD	TBD	To ensure expenditures align with policy priorities given federal and state legislative changes.	Recommended by the Legislative Ad Hoc during a report out at the 9/4/2025 Board meeting. This ad hoc has yet to be appointed.	TBD

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

9. Approve Actions Related to Requesting Additional Funds for the Member and Population Health Needs Assessment

Contacts

Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981

Recommended Actions

1. Authorize the Chief Executive Officer to execute a contract amendment with the National Opinion Research Center to add up to $60,000 from existing reserves for an increase in the member survey sample size as part of the Member and Population Health Needs Assessment.

Background

On April 4, 2024, the Board of Directors (Board) approved a reallocation of $1 million from the previously approved 2023 Member Health Needs Assessment (MHNA) to fund the 2024 Member and Population Health Needs Assessment (MPHNA). On March 6, 2025, pursuant to a formal procurement, the Board approved a contract with National Opinion Research Center (NORC) for the completion of the Member and Population Health Needs Assessment and Health Equity Asset Mapping project in the amount of $966,384. This contract was executed on March 14, 2025.

The scope of work for the project includes:

1. Assess the whole-person health needs and preferences of CalOptima Health members;
2. Assess community assets to inform the development of health equity interventions and community investments;
3. Provide best practices to develop programs and strategic approaches that best serve all Orange County Medi-Cal members; and
4. Assist with developing the Medi-Cal Population Needs Assessment (PNA) and the National Committee for Quality Assurance (NCQA) Health Plan Accreditation and Health Equity Accreditation member assessments.

The tasks outlined in the contract are provided in the table below.

Phase	Timeframe
Phase 1 – Study Design & Stakeholder Engagement Strategy	Month 1
Phase 2 – Secondary Data Collection and Analysis	Months 2 – 4
Phase 3 – Primary Data Collection and Analysis (including member and provider surveys, focus groups, and key informant interviews)	Months 2 – 6
Phase 4 – MPHNA Report Development	Months 7 – 9
Phase 5 – Health Equity Asset Mapping	Months 7 – 9

On June 18, 2025, CalOptima Health executed a contract amendment to the NORC contract to add $33,338 to account for the administration of member gift card incentives for completion of the member survey or participation in a focus group, with a revised contract total of $999,722.

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Discussion

NORC has been executing on the tasks outlined in the contract since April 2025. Completed activities include:

- Development of a member survey instrument and associated outreach materials
- Development of a provider survey instrument and associated outreach materials
- Development of a focus group discussion guide
- Execution of the provider survey, resulting in 301 responses
- Three focus groups with a total of 10 planned populations of focus
- Three key informant interviews out of 15 planned interviews
- Launch of the member survey on October 23
- Distribution of member survey postcards through community events and the Street Medicine and PACE programs

The member survey originally targeted a sample of about 25,000 members. This sample was selected to be representative of total CalOptima Health member demographics while resulting in a sufficient sample from which to draw conclusions about member needs. In addition, CalOptima Health is utilizing an additional 1,000 survey postcards to do community outreach to ensure survey responses from hard-to-reach groups. The table below presents the original methodology for the sampling of CalOptima Health members.

Race/Ethnicity	**CalOptima Health Population Percentage**	**Projected Response Rate**	**Study Sampling Frame Count**	**Anticipated Sample Size**
White, Non- Hispanic	14%	6.2	6,339	393
Hispanic or Latino	48%	12.5	3,144	393
Vietnamese	12%	5.3	7,415	393
All Other Races/Ethnicities	26%	4.7	8,355	393
Totals	**100%**	**7.2**	**25,253**	**1,572**

The member survey has been in the field since October 23, 2025. Since then, 593 member survey responses from the original survey sample have been received. Based on the survey responses received thus far, NORC has observed that the response rate among Hispanic/Latino members has been much lower than expected and lower than other demographic groups that received the survey for completion. Response numbers for each race/ethnicity are presented in the table below.

Race/Ethnicity	**# of Completes**
Hispanic/Latino	43
White	177
Vietnamese	134
Other	239
Total	**593**

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To increase the response rate among Hispanic/Latino members, staff is requesting to increase the NORC contract by up to $60,000 to survey an additional 11,411 Hispanic/Latino members.

Fiscal Impact
An appropriation of up to $60,000 from existing reserves will fund the increase in the member survey sample size as part of the MPHNA.

Rationale for Recommendation
The additional investment in the MPHNA will help to ensure the member survey sample is representative of CalOptima Health's Hispanic and Latino membership.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by Recommended Board Action
2. Previous Board Action April 4, 2024, "Approve Actions Related to the 2024 CalOptima Health Member and Population Health Needs Assessment."
3. Previous Board Action March 6, 2025, "Approve Actions Related to a Contract with the National Opinion Research Center to Conduct a Member and Population Health Needs Assessment."

/s/ Michael Hunn *11/25/2025*
Authorized Signature **Date**

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Attachment to the December 4, 2025 Board of Directors Meeting – Agenda Item 9

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
The National Opinion Research Center (NORC)	55 East Monroe St, 30th Floor	Chicago	IL	60603

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

16. Approve Actions Related to the 2024 CalOptima Health Member and Population Health Needs Assessment

Contact

Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981

Recommended Actions

1. Authorize reallocation of remaining unspent funds, approximately $1.0 million, from the Board-approved initiative CalOptima Health 2023 Member Health Needs Assessment (MHNA) to fund the 2024 Member and Population Health Needs Assessment (MPHNA).
2. Approve the scope of work (SOW) for the 2024 CalOptima Health MPHNA and release of a request for proposals (RFP).

Background

In 2018, CalOptima Health conducted a Member Health Needs Assessment (MHNA) to identify the focused needs of Orange County's Medi-Cal beneficiaries, in particular to assess the health needs and preferences of diverse populations. The results of the 2018 assessment highlighted key findings in the areas of:

- Social Determinants of Health,
- Mental Health,
- Primary Care,
- Provider Access, and
- Dental Care.

On November 3, 2022, the CalOptima Health Board of Directors (Board) approved $1 million from reserves to fund the CalOptima Health 2023 MHNA to conduct an expanded and refreshed assessment and to take into account the needs of members after the COVID-19 pandemic. CalOptima Health released an RFP for consultant services on November 8, 2022, and the evaluation committee selected Harder + Company Community Research (Harder + Company) to conduct the assessment. On February 2, 2023, the Board approved the contract with Harder + Company in an amount not to exceed $1,250,000 and appropriated up to $250,000 from reserves to fund the shortfall. The contract was to assess and support the following areas:

- Implementing Department of Health Care Services (DHCS) population health strategies (*e.g.*, population health management strategy, support health and opportunity for children and families, comprehensive quality strategy, etc.) and California Advancing and Innovating Medi-Cal (now referred to as Medi-Cal Transformation) initiatives.
- Improving member health outcomes by identifying opportunities and solutions of health care access specific to each ethnic community.

- Identifying and establishing opportunities for meaningful engagement and partnerships regarding health and well-being, especially for underserved and difficult-to-reach populations.
- Addressing health equity and influences of the social determinants of health.
- Highlighting inequities that have/were amplified by the COVID-19 pandemic and identifying sustainable solutions.

Following approval of the Harder + Company contract in 2023, new regulatory and accreditation requirements from DHCS and the National Committee for Quality Assurance (NCQA) impacted the activities CalOptima Health must perform related to population health assessments. As CalOptima Health began working with Harder + Company, CalOptima Health staff discovered that these new requirements were not accounted for in the Board approved SOW and contract. Based on the new changes to regulatory and accreditation requirements, CalOptima Health staff chose to end the Harder + Company contract in January 2024 and develop a new SOW and project approach.

Discussion

Given the changes to regulatory requirements under Medi-Cal Transformation and NCQA accreditation requirements, staff recommends Board approval of the new SOW and release of an RFP to procure the services of a research consultant with knowledge of Orange County's diverse populations and opportunities for meaningful outreach and engagement to conduct the 2024 MPHNA. The new MPHNA will be a more comprehensive assessment and will be expanded to help CalOptima Health assess whole-person health needs and identify additional barriers to access to care, gaps in services, and disparities in health among members and the general community. The 2024 MPHNA will utilize existing CalOptima Health member data, existing community data provided by the county Community Health Needs Assessment, and other sources of data. The 2024 MPHNA may also utilize a small member survey and member focus groups to obtain member input.

There is approximately $1.0 million in unspent funds available for reallocation after the termination of the Harder + Company contract. Staff recommends reallocation of the remaining funds to support the CalOptima Health 2024 MPHNA. If approved, CalOptima Health will issue an RFP for consultant services for the new SOW. Proposals received will be evaluated by an evaluation committee. Upon completion of the RFP process, staff will make a recommendation for selection of a vendor to the Board at a future Board meeting.

Fiscal Impact

Previous Board actions on November 3, 2022, and February 2, 2023, authorized $1.25 million to fund the CalOptima Health 2023 MHNA. The remaining unspent funds of approximately $1.0 million committed for this Board-approved initiative will fund the CalOptima Health 2024 MPHNA.

Rationale for Recommendation

Approving the recommended actions will allow CalOptima Health to move forward with a new SOW and obtain a contractor that can support all regulatory and accreditation requirements for member and population assessment.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Proposed CalOptima Health Member and Population Health Needs Assessment (MPHNA) 2024 Scope of Work.
2. Previous Board Action November 3, 2022, "Approve Actions Related to CalOptima Health Member Health Needs Assessment 2023."
3. Previous Board Action February 2, 2023, "Authorize Contract with Vendor to Assist with Member Health Needs Assessment 2023 Activities."

/s/ Michael Hunn *03/29/2024*
Authorized Signature **Date**

SCOPE OF WORK
CalOptima Health Member and Population Health Needs Assessment

I. OBJECTIVE

CalOptima Health is seeking a contractor to conduct a comprehensive Member and Population Health Needs Assessment (MPHNA). The purpose of the MPHNA is to:

1. Assess the whole-person health needs and preferences of CalOptima Health members.
2. Inform the development of programs and strategic approaches to best serve all Orange County Medi-Cal members.
3. Meet the member and population health needs assessment requirements of the Medi-Cal Population Needs Assessment (PNA) and the National Committee for Quality Assurance (NCQA) Health Plan Accreditation and Health Equity Accreditation member assessments.

II. SCOPE OF WORK

CalOptima Health seeks a contractor to provide professional research and analytical services that has detailed knowledge of Medi-Cal, Medicare, and Orange County populations. The contractor shall have demonstrated expertise and knowledge in analyzing population and member level data and producing detailed analyses and dashboards to present study findings. The contractor shall be able to analyze existing CalOptima Health and community data sources and also propose approaches to obtaining member, provider, and community input through interviews, surveys and/or focus groups.

Consulting services will be for the purpose of taking a strategic approach to consolidating related CalOptima Health efforts to assess population health data (including members and potential members) that meets deliverable requirements as outlined by the Department of Health Care Services (DHCS), NCQA, and other related requirements. These contracted services will inform and support CalOptima Health in achieving the following objectives:

- Meet the requirements of DHCS population health initiatives, e.g., Population Health Management Strategy, Population Needs Assessment (PNA), and Medi-Cal Transformation initiatives.
- Meet the requirements of NCQA Health Plan Accreditation PHM Standards, PHM 2, including Elements A (Data Integration), B (Population Assessment), and D (Segmentation).
- Meet the requirements of NCQA Health Equity Accreditation as applicable.
- Understand the detailed member and population needs of our member population and community, including in the domains outlined in this scope of work.

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- Understand member experience with CalOptima Health services and recommendations for future service offerings.
- Identify opportunities to advance health equity with our member population.

The MPHNA areas of assessment will include *but not be limited to* the attributes/domains of the CalOptima Health member population as outlined in the table below. CalOptima Health aims to assess these areas for our entire member population as well as for subsets of the member population, including child and adolescent members, members with disabilities, members with serious mental illness or serious emotional disturbance, members of racial or ethnic groups, members with limited English proficiency, and other relevant subpopulations.

Assessment Domain	Areas for Analysis
Demographics of Member Population	• Age • Race • Ethnicity • Language • Sexual Orientation • Gender Identity • Etc.
Health Status and Health Conditions	• Chronic conditions/disease prevalence (e.g., asthma, diabetes, chronic obstructive pulmonary disease, etc.) • Member risk profile • Births • High-risk pregnancy • Behavioral health conditions • Smoking • Substance use disorder • Disparities • Vaccination rates • Select Healthcare Effectiveness Data and Information Set (HEDIS) measures
Social Conditions	• Social determinants of health needs • Barriers to getting needed help • Barriers to economic mobility • Transportation challenges • Etc.
Health Equity	• Challenges with accessing care (e.g., language, health literacy, affinity with providers, etc.) • Challenges with accessing social supports • Member experience • Cultural preferences

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Assessment Domain	Areas for Analysis
Access to Care and Supports	• Barriers to accessing care and support (e.g., childcare, hours of operation, not enough information, unable to find a provider, no appointments available/delays in timely access, etc.) • Access to behavioral health services and barriers • Services most and least utilized • Unmet care needs • Eligibility loss/churn/income changes
CalOptima Health Services & Supports	• Experience with CalAIM services • Medicare supplemental benefits • Participation in other coverage programs • How CalOptima Health partners in their communities

The project shall incorporate coordination and collaboration with CalOptima Health and external partners (e.g., Orange County Health Care Agency and Social Services Agency) to provide complementary information and avoid duplication of efforts to the extent possible.

III. CONSULTANT/CONTRACTOR'S RESPONSIBILITIES

Consultant/Contractor shall:

1. Develop a study design to identify, synthesize, and analyze all available data to assess member health and population needs, including but not limited to:
    a. CalOptima Health internal data
    b. Additional data sources, i.e., the county Community Health Needs Assessment, etc.
    c. Member input through a small-scale member survey to fill gaps in existing data, focus groups, etc.
    d. Community input
    e. Provider input

    The Study design must outline study methodologies, data sources, and data collection methods. The study design must be presented to CalOptima Health for review and input prior to finalization. It will also be presented to the CalOptima Health Member and Provider Advisory Committee and potentially other community forums for comment.

2. Develop a detailed project plan that outlines a timeline with duration of tasks and Consultant/Contractor resources and responsibilities. The timeline should be developed in partnership with CalOptima Health staff to account for regulatory approval timelines where necessary. The project plan must be updated throughout the project if timelines change.

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3. Develop MPHNA deliverables that will be presented to CalOptima Health for review and approval, including if applicable:
    a. Final survey instruments (e.g., member, provider, key informant)
    b. Focus group facilitation guides, presentations, and other relevant materials
    c. Outreach and engagement materials for member communication and community organization communication

    All member facing materials must be translated in all threshold languages. All member facing materials must also be submitted for review to CalOptima Health. CalOptima Health may be required to submit certain materials to the Department of Health Care Services for review and approval, and timelines should be constructed to allow such approval time.

4. Facilitate member outreach and engagement activities in threshold languages in partnership with CalOptima Health and community organizations (e.g. member incentives, focus groups, community, or member forums, etc.) as needed to support the approved study design.

5. Provide interim assessment deliverables for NCQA filings if needed. These interim deliverables may include a preliminary assessment of internal and secondary data sources and obtaining member input from existing member committees and forums.

6. Develop final MPHNA report and executive summary presentation to CalOptima Health and its leadership detailing assessment findings and recommendations.

7. Produce dashboard for member assessment that can be utilized by CalOptima Health staff and stakeholders for ongoing population needs assessment reporting.

8. Deliver data set collected and synthesized through the conduct of the assessment study.

9. Schedule and conduct regular meetings with CalOptima Health staff to present relevant findings and project status.

10. Present MPHNA findings to the CalOptima Health Board of Directors.

The Consultant/Contractor must perform all work according to industry and professional standards and in a manner satisfactory to CalOptima Health and, if applicable, regulatory and accreditation requirements.

The Consultant/Contractor may propose to utilize subcontracted services for survey administration and/or focus group facilitation to ensure alignment of skills with services. The Consultant/Contractor is responsible for ensuring that performance and completion of project deliverables by any and all subcontractors align with the responsibilities outlined in this scope of work.

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IV. CALOPTIMA HEALTH'S RESPONSIBILITIES

CalOptima Health staff shall:

1. Provide a point of contact and meet regularly with the Consultant/Contractor to discuss project status, open questions, and deliverable development.
2. Provide documentation on requirements for Consultant/Contractor to review and key resources and department point of contacts.
3. Provide guidance on regulatory and CalOptima Health's requirements.
4. Work collaboratively with Consultant/Contractor to promote member and provider surveys, if included in the study design.
5. Provide and distribute Member Incentives (if applicable).
6. Utilize existing community relationships to make introductions for the Consultant/Contractor to connect with these organizations.
7. Facilitate CalOptima Health internal approvals and DHCS regulatory approvals as needed.
8. Provide Consultant/Contractor with points of contact to administer community leader/key informant and provider interviews (if applicable).

V. TIMELINES

This contract will continue through the completion of deliverables outlined in the Scope of Work, with a framework that can be leveraged for annual refreshing on a go-forward basis of the MPHNA to meet NCQA requirements. Consultant/Contractor shall:

1. Begin project planning in July 2024, with implementation through December 2024.
2. On an ongoing basis, meet regularly with CalOptima Health to assess progress and opportunities and share findings with CalOptima Health.

VI. PRICING

The Consultant/Contractor should propose a budget and pricing for this project.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

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

Report Item
8. Approve Actions Related to the CalOptima Health Member Health Needs Assessment 2023

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Government Affairs and Strategic Development, (657) 900-1096

Recommended Actions
1. Approve the scope of work (SOW) for the CalOptima Health 2023 Member Health Needs Assessment (MHNA) and release a request for proposal.
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $1 million from existing reserves for the CalOptima Health 2023 MHNA.

Background
In 2017-18, CalOptima Health conducted a comprehensive MHNA of approximately 5,800 members to identify the focused needs of Orange County's Medi-Cal beneficiaries – in particular, ethnic minorities and their health needs and interests. The results of the 2017-18 assessment highlighted key findings in the areas of social determinants of health, mental health, primary care, provider access, and dental care.

Assessments such as Population Needs Assessment, Health Effectiveness Data and Information Set (HEDIS) reports, and member satisfaction surveys are periodically conducted to identify the health risks, beliefs, and practices of CalOptima Health's Medi-Cal members. However, these assessments and surveys do not represent the full scope and depth of the health needs of CalOptima Health members. In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: 1) Same Day Treatment Authorizations; 2) Real-Time Claims Payments; and 3) Annual Assessments of Members' Social Determinants of Health. The MHNA will provide the foundational data for CalOptima Health's annual social determinants of health assessment.

Discussion
Given the inequities revealed through the COVID-19 pandemic and an increase in CalOptima Health's membership, staff recommends engaging the professional services of a research consultant to conduct another MHNA in Q1 2023. The MHNA will be an expanded version of the original assessment completed in 2017-18, surveying at least 10% of CalOptima Health's membership, to help CalOptima Health identify additional and/or confirm the needs of members, barriers to accessing care, gaps in services, and disparities in health among members and the general community.

The 2023 MHNA will assist CalOptima Health with:
- Implementing Department of Health Care Services population health strategies (e.g., population health management strategy, support health and opportunity for children and families,

comprehensive quality strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives.
- Improving member health outcomes by identifying opportunities and solutions of health care access specific to each ethnic community.
- Identifying and establishing opportunities for meaningful engagement and partnerships regarding health and well-being, especially for underserved and difficult-to-reach populations.
- Addressing health equity and influences of the social determinants of health.
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions.

Staff recommends that the Board authorize $1 million from existing reserves to conduct the 2023 MHNA as the results of the MHNA will be utilized to inform strategic initiative development (e.g., health equity, social determinants of health, homeless health etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on the specific needs of Orange County's Medi-Cal beneficiaries.

Fiscal Impact
The recommended action is unbudgeted. An appropriation of up to $1 million from existing reserves will fund this action.

Rationale for Recommendation
The recommended actions will support CalOptima Health's health equity and social determinants of health strategies to improve the overall health of CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed CalOptima Health Member Health Needs Assessment 2023 Scope of Work

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

SCOPE OF WORK
Member Needs Health Assessment 2023

I. OBJECTIVE

CalOptima Health is seeking to engage the professional services of a community research consultant with knowledge of multi-cultural populations and strategies for improved program engagement to conduct a comprehensive Member Health Needs Assessment (MHNA) 2023.

The MHNA 2023 will be an expanded version of the original assessment completed in 2017-18, ensuring a diverse group of at least 10% of CalOptima Health members at the time the survey is conducted are surveyed. Given the inequities revealed through the COVID-19 pandemic, the MHNA 2023 assessment will result in a final report that includes recommendations on how to address the needs of members and newly identified populations, barriers to access care, gaps in services and disparities in health among members. The project shall incorporate coordination and collaboration (as feasible) with external partners (e.g. Orange County Health Care Agency and Social Services Agency) to provide complementary information and avoid duplication of efforts to the extent possible.

The MHNA 2023 will assist CalOptima Health with:

- Implementing DHCS population health strategies (e.g., Population Health Management Strategy, Support Health and Opportunity for Children and Families, Comprehensive Quality Strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives
- Improving member health outcomes by identifying opportunities to improve health care access specific to each ethnic community
- Identifying and establishing opportunities for meaningful engagement with new partnering organizations regarding health and well-being, especially for underserved, difficult-to-reach and newly identified populations (increase capacity and extend services)
- Analyzing social determinants of health impacting CalOptima Health members and designing strategies, programs and interventions to address them (e.g., food and nutritional assistance, medically prescribed food boxes, linkages to housing support and other community and social support services, etc.)
- Identifying opportunities for partnership with social service type providers
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions
- Identifying and recommending unique services for new populations, such as the justice-involved and foster care populations

The anticipated launch date for this project is February 2023. A final report shall be prepared and presented to the Board by the fourth quarter of 2023.

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II. SCOPE OF WORK

1. PRODUCTS/SERVICES

A. Project Plan and Budget

1. Proposal project plans must clearly articulate VENDOR approach and address the following elements:
    a. Development of survey instruments and associated facilitation guides,
    b. Facilitation of in-person and/or virtual community town halls/forums and focus group meetings,
    c. Data collection and analysis,
    d. Development of draft report by the third quarter of 2023, executive summary, final report and presentation to the Board by the fourth quarter of 2023.
    e. Include detailed timeline with duration of tasks (by number of days) and VENDOR resources and responsibilities.
    f. Proposed number of survey collection to ensure results are statistically significant and representative of CalOptima Health members.
2. Proposal must include a detailed project budget and justifications based on proposed project plan, timeline, direct labor costs (including hourly rates), travel, subcontracts (if applicable), supplies/materials, etc.
3. Proposals must outline how VENDOR will safeguard and store member information and protected health information that may be obtained throughout the course of the project.

B. Survey Instruments and Facilitation Guides

1. VENDOR shall determine appropriate methodologies and resources to be used for development of the MHNA 2023 survey instruments, group facilitation guides and/or other assessment tools. VENDOR will provide recommendations and seek input from CalOptima Health staff and Committee on development and finalization of survey instruments, facilitation guides, presentations, etc.
2. The final survey instruments (e.g., member, provider, key informant) and facilitation guides may leverage information gathered by VENDOR, through focus groups, other CalOptima Health surveys and clinical data, other internal data collection efforts and external secondary data sources e.g. Advance OC 2020 Social Progress Index, the 27th Annual Report on the Conditions of Children in Orange County (Orange County Children's Partnership), 2021-2022 Orange County Community Indicators Report, 2022 Report on Aging in Orange County, (Orange County Strategic Plan for Aging), etc..

C. Survey Administration and Group Meeting Facilitation

1. VENDOR shall recommend the best practice of survey administration for members, such as: mailed and online surveys, telephone interviews, text messaging, in-person data collection components, etc.
    a. Mailed/online/text messaging member survey and telephone scripts will be translated into Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese (additional languages may be included depending on preliminary research findings) by CalOptima Health.

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b. If selected, telephone interviews are to be conducted by VENDOR, and must be conducted in English, Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese by VENDOR.
c. Provider surveys may be mailed and/or provided as an online survey option.
d. The VENDOR shall have enough trained, experienced interviewers capable to conduct the identified volume of interviews and other data collection activities in the identified languages.

2. CalOptima Health staff will work collaboratively with VENDOR to promote member surveys (if applicable) at:
   a. In-person and/or virtual community town halls/forums and focus groups,
   b. Community resource and health fair events,
   c. New member orientations,
   d. Health education seminars,
   e. Faith-based group meetings,
   f. Other events/activities as identified, etc.

   CalOptima Health staff can utilize existing community relationships to make introductions for the VENDOR to connect with these organizations. VENDOR shall coordinate the events.
3. CalOptima Health staff can provide VENDOR with points of contact to administer provider and community leader/key informant interviews (if applicable) either virtually and/or at:
   a. Provider offices,
   b. Network forums,
   c. Community organization offices, and
   d. Other locations where providers and community leaders/key informants congregate.

   VENDOR will lead group facilitation, data collection and distribution of nonmonetary gift cards (if applicable) at such events.
4. VENDOR is responsible for tabulation of data (e.g., member, provider and key stakeholder data) collected through the agreed upon methods.
5. VENDOR is responsible for evaluation and analysis of all data collected and synthesis with CalOptima Health clinical or other data, as well as other secondary source data to inform identification of key findings in the MHNA report and executive summary, of which will summarize findings and include recommendations.
6. VENDOR will provide all raw data to CalOptima Health.

D. Member Incentives
1. If applicable, VENDOR shall receive and secure member incentives (i.e., digital nonmonetary gift cards) from CalOptima Health. Distribute and track incentive to member upon receipt of completed survey (mailed, telephone, text and/or in-person completion).
   a. Establish a mechanism for safekeeping of the gift cards from loss, theft, or delivery to non-CalOptima Health Medi-Cal members. The mechanism for safekeeping of the gift cards shall be mutually agreed upon between VENDOR and CalOptima Health.
   b. Only use the gift cards consistent with this scope of work. A maximum of one incentive per survey respondent will be awarded and for participation in one focus group, if applicable.

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c. Coordinate with CalOptima Health staff to validate Medi-Cal eligibility and CalOptima Health membership prior to distributing the gift cards.
d. Return to CalOptima Health all gift cards that were not distributed to the designated CalOptima Health members, within thirty (30) calendar days of completion of all member surveys and focus groups.
e. VENDOR will establish an automated method to report to CalOptima Health following the delivery of the gift card, of which the minimum requirements include:
    i. The date of delivery or mailing and number of gift cards received by VENDOR from CalOptima Health.
    ii. A list of eligible members who received the gift card, including but not limited to member name, member CalOptima Health ID, and the date member participated in the survey or focus group.
    iii. Whether the gift card was hand delivered or mailed.
    iv. The number of gift cards remaining to be distributed.
f. VENDOR shall reasonably ensure use of the gift cards are solely used as contemplated in this Agreement and in compliance with DHCS requirements (gift cards is not to be used to purchase firearms, tobacco, alcohol, etc.). CalOptima Health retains the right to recover any gift card(s) or face value of such gift card(s) if it (or any of its regulators) determines that, as a result of VENDOR's negligence, the gift card(s) were not provided in accordance with (1) the terms of this Agreement; or (2) applicable federal and state laws, regulations, guidance and/or funding source requirement. This Section shall survive the termination of this Agreement.

E. Member Health Needs Assessment 2023 Report and Executive Summary
1. Once survey administration, data collection and analysis are finished, VENDOR will seek input and feedback from CalOptima Health executives, develop a draft written report, executive summary and final written report of findings and recommendations for CalOptima Health, and will present findings to the Board of Directors (the Board) in the form of a public presentation.
2. The executive summary and final report will be used for internal and external publication. The report shall include details on main issues that current CalOptima Health members encounter, the barriers to those issues, potential solutions and methods of prevention (if available). Additionally, the report shall include consideration(s) and recommendation(s) of newly identified populations, such as the justice-involved and foster care populations.

   The Board will be provided regular updates by CalOptima Health staff on the progress of the MHNA 2023 activities. CalOptima Health staff will share the draft written report with the Board and with the MHNA 2023 Committee for review and comment. If applicable, VENDOR will incorporate comments into the draft report to generate the final report, executive summary and presentation.

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CalOptima Health Board Action Agenda Referral

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

Report Item

14. Authorize Contract with Vendor to Assist with Member Health Needs Assessment 2023 Activities

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operations Officer, (714) 923 8834

Recommended Actions

1. Authorize Chief Executive Officer to execute a contract with Harder+Company Community Research, Inc. (Harder+Company) to assist with the Member Health Needs Assessment 2023 activities in an amount not to exceed $1,250,000; and
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $250,000 from existing reserves for the contract with Harder+Company.

Background

In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: (1) Same Day Treatment Authorizations; (2) Real-Time Claims Payments; and (3) Annual Assessments of Members' Social Determinants of Health. The Member Health Needs Assessment (MHNA) will provide the foundational data for CalOptima Health's annual social determinants of health assessment. On November 3, 2022, the CalOptima Health Board of Directors approved the scope of work and unbudgeted expenditures for the CalOptima Health 2023 MHNA. The MHNA will be utilized to inform strategic development (e.g., health equity, social drivers of health, homeless health, etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on specific needs of Orange County's Medi-Cal beneficiaries.

In selecting the recommended vendor, a request for proposal (RFP) process for consultant services was issued by CalOptima Health on November 8, 2022, and a total of two proposals were received. A proposal evaluation committee comprised of staff from the CalAIM, Office of the CEO, Strategic Development, and Vendor Management departments – plus an external subject matter expert reviewed the submitted proposals. The consultants were also interviewed by the evaluation committee. After the evaluation of proposals and the interviews, the proposal with the highest overall score was selected.

Vendor	Proposal Score	Interview Score	Combined Scores
Harder+Company	4.68	4.74	4.71
Advance OC	3.67	3.78	3.73

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Discussion
Staff recommends Harder+Company as the selected vendor due to completeness of its proposal, as well as its knowledge and experience in completing community health needs assessments with local organizations, health plans, and other public health care agencies. Harder+Company, along with its subcontractor, Social Science Research Center at California State University, Fullerton (CSUF), has in-depth experience and subject matter expertise in the development and administration of multiple survey tools and methods as well as data analysis and final reporting and recommendations. The Social Science Research Center (SSRC) at CSUF will assist Harder+Company in collecting the member survey and developing tools and support analysis. In addition, due to SSRC's local university setting and expertise, Harder+Company will work with staff to connect to local community-based organizations.

Harder+Company will assist staff with the activities associated with the 2023 MHNA, including (1) development of a best practice model project plan, (2) development of survey instruments and facilitation guides, (3) administration of member and provider/key informant surveys (mail/online, telephone, in-person and facilitation at community town halls/forums and focus groups), (4) data sampling, collection and analysis combined with evaluation of internally produced clinical/survey data and external secondary data sources, and (5) development of the final health needs assessment report and recommendations.

Fiscal Impact
A previous Board action on November 3, 2022, authorized and appropriated up to $1 million from existing reserves to fund the CalOptima Health 2023 MHNA. An appropriation of up to $250,000 from existing reserves will fund the unbudgeted shortfall amount to execute the contract with Harder+Company.

Rationale for Recommendation
The 2023 MHNA will support CalOptima Health's health equity and social drivers of health strategies to improve the overall health of CalOptima Health members. Harder+Company had the highest score from their proposal and interview. It also successfully assisted CalOptima Health with 2017-18 MHNA, as well as the evaluation of CalOptima Health's Shape Your Life Program in 2019.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Previous Board Action November 3, 2022, "Approve Actions Related to the CalOptima Health Member Needs Assessment 2023"

Board Action

Board Meeting Dates	Action	Not to Exceed Amount
November 3, 2022	Approve Actions Related to the CalOptima Health Member Needs Assessment 2023	Up to $1 million from existing reserves

/s/ Michael Hunn *01/26/2023*
Authorized Signature **Date**

Attachment to the February 2, 2023 Board of Directors Meeting – Agenda Item 14

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Harder + Company Community Research, Inc.	3965 5th Avenue, Suite 420	San Diego	CA	92103

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CalOptima Health Board Action Agenda Referral

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

Report Item

8. Approve Actions Related to the CalOptima Health Member Health Needs Assessment 2023

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Government Affairs and Strategic Development, (657) 900-1096

Recommended Actions

1. Approve the scope of work (SOW) for the CalOptima Health 2023 Member Health Needs Assessment (MHNA) and release a request for proposal.
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $1 million from existing reserves for the CalOptima Health 2023 MHNA.

Background

In 2017-18, CalOptima Health conducted a comprehensive MHNA of approximately 5,800 members to identify the focused needs of Orange County's Medi-Cal beneficiaries – in particular, ethnic minorities and their health needs and interests. The results of the 2017-18 assessment highlighted key findings in the areas of social determinants of health, mental health, primary care, provider access, and dental care.

Assessments such as Population Needs Assessment, Health Effectiveness Data and Information Set (HEDIS) reports, and member satisfaction surveys are periodically conducted to identify the health risks, beliefs, and practices of CalOptima Health's Medi-Cal members. However, these assessments and surveys do not represent the full scope and depth of the health needs of CalOptima Health members. In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: 1) Same Day Treatment Authorizations; 2) Real-Time Claims Payments; and 3) Annual Assessments of Members' Social Determinants of Health. The MHNA will provide the foundational data for CalOptima Health's annual social determinants of health assessment.

Discussion

Given the inequities revealed through the COVID-19 pandemic and an increase in CalOptima Health's membership, staff recommends engaging the professional services of a research consultant to conduct another MHNA in Q1 2023. The MHNA will be an expanded version of the original assessment completed in 2017-18, surveying at least 10% of CalOptima Health's membership, to help CalOptima Health identify additional and/or confirm the needs of members, barriers to accessing care, gaps in services, and disparities in health among members and the general community.

The 2023 MHNA will assist CalOptima Health with:

- Implementing Department of Health Care Services population health strategies (e.g., population health management strategy, support health and opportunity for children and families,

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comprehensive quality strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives.
- Improving member health outcomes by identifying opportunities and solutions of health care access specific to each ethnic community.
- Identifying and establishing opportunities for meaningful engagement and partnerships regarding health and well-being, especially for underserved and difficult-to-reach populations.
- Addressing health equity and influences of the social determinants of health.
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions.

Staff recommends that the Board authorize $1 million from existing reserves to conduct the 2023 MHNA as the results of the MHNA will be utilized to inform strategic initiative development (e.g., health equity, social determinants of health, homeless health etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on the specific needs of Orange County's Medi-Cal beneficiaries.

Fiscal Impact
The recommended action is unbudgeted. An appropriation of up to $1 million from existing reserves will fund this action.

Rationale for Recommendation
The recommended actions will support CalOptima Health's health equity and social determinants of health strategies to improve the overall health of CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed CalOptima Health Member Health Needs Assessment 2023 Scope of Work

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

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SCOPE OF WORK
Member Needs Health Assessment 2023

I. OBJECTIVE

CalOptima Health is seeking to engage the professional services of a community research consultant with knowledge of multi-cultural populations and strategies for improved program engagement to conduct a comprehensive Member Health Needs Assessment (MHNA) 2023.

The MHNA 2023 will be an expanded version of the original assessment completed in 2017-18, ensuring a diverse group of at least 10% of CalOptima Health members at the time the survey is conducted are surveyed. Given the inequities revealed through the COVID-19 pandemic, the MHNA 2023 assessment will result in a final report that includes recommendations on how to address the needs of members and newly identified populations, barriers to access care, gaps in services and disparities in health among members. The project shall incorporate coordination and collaboration (as feasible) with external partners (e.g. Orange County Health Care Agency and Social Services Agency) to provide complementary information and avoid duplication of efforts to the extent possible.

The MHNA 2023 will assist CalOptima Health with:

- Implementing DHCS population health strategies (e.g., Population Health Management Strategy, Support Health and Opportunity for Children and Families, Comprehensive Quality Strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives
- Improving member health outcomes by identifying opportunities to improve health care access specific to each ethnic community
- Identifying and establishing opportunities for meaningful engagement with new partnering organizations regarding health and well-being, especially for underserved, difficult-to-reach and newly identified populations (increase capacity and extend services)
- Analyzing social determinants of health impacting CalOptima Health members and designing strategies, programs and interventions to address them (e.g., food and nutritional assistance, medically prescribed food boxes, linkages to housing support and other community and social support services, etc.)
- Identifying opportunities for partnership with social service type providers
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions
- Identifying and recommending unique services for new populations, such as the justice-involved and foster care populations

The anticipated launch date for this project is February 2023. A final report shall be prepared and presented to the Board by the fourth quarter of 2023.

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II. SCOPE OF WORK

1. PRODUCTS/SERVICES

A. Project Plan and Budget

1. Proposal project plans must clearly articulate VENDOR approach and address the following elements:
    a. Development of survey instruments and associated facilitation guides,
    b. Facilitation of in-person and/or virtual community town halls/forums and focus group meetings,
    c. Data collection and analysis,
    d. Development of draft report by the third quarter of 2023, executive summary, final report and presentation to the Board by the fourth quarter of 2023.
    e. Include detailed timeline with duration of tasks (by number of days) and VENDOR resources and responsibilities.
    f. Proposed number of survey collection to ensure results are statistically significant and representative of CalOptima Health members.
2. Proposal must include a detailed project budget and justifications based on proposed project plan, timeline, direct labor costs (including hourly rates), travel, subcontracts (if applicable), supplies/materials, etc.
3. Proposals must outline how VENDOR will safeguard and store member information and protected health information that may be obtained throughout the course of the project.

B. Survey Instruments and Facilitation Guides

1. VENDOR shall determine appropriate methodologies and resources to be used for development of the MHNA 2023 survey instruments, group facilitation guides and/or other assessment tools. VENDOR will provide recommendations and seek input from CalOptima Health staff and Committee on development and finalization of survey instruments, facilitation guides, presentations, etc.
2. The final survey instruments (e.g., member, provider, key informant) and facilitation guides may leverage information gathered by VENDOR, through focus groups, other CalOptima Health surveys and clinical data, other internal data collection efforts and external secondary data sources e.g. Advance OC 2020 Social Progress Index, the 27th Annual Report on the Conditions of Children in Orange County (Orange County Children's Partnership), 2021-2022 Orange County Community Indicators Report, 2022 Report on Aging in Orange County, (Orange County Strategic Plan for Aging), etc..

C. Survey Administration and Group Meeting Facilitation

1. VENDOR shall recommend the best practice of survey administration for members, such as: mailed and online surveys, telephone interviews, text messaging, in-person data collection components, etc.
    a. Mailed/online/text messaging member survey and telephone scripts will be translated into Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese (additional languages may be included depending on preliminary research findings) by CalOptima Health.

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b. If selected, telephone interviews are to be conducted by VENDOR, and must be conducted in English, Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese by VENDOR.
c. Provider surveys may be mailed and/or provided as an online survey option.
d. The VENDOR shall have enough trained, experienced interviewers capable to conduct the identified volume of interviews and other data collection activities in the identified languages.

2. CalOptima Health staff will work collaboratively with VENDOR to promote member surveys (if applicable) at:
   a. In-person and/or virtual community town halls/forums and focus groups,
   b. Community resource and health fair events,
   c. New member orientations,
   d. Health education seminars,
   e. Faith-based group meetings,
   f. Other events/activities as identified, etc.

   CalOptima Health staff can utilize existing community relationships to make introductions for the VENDOR to connect with these organizations. VENDOR shall coordinate the events.
3. CalOptima Health staff can provide VENDOR with points of contact to administer provider and community leader/key informant interviews (if applicable) either virtually and/or at:
   a. Provider offices,
   b. Network forums,
   c. Community organization offices, and
   d. Other locations where providers and community leaders/key informants congregate.

   VENDOR will lead group facilitation, data collection and distribution of nonmonetary gift cards (if applicable) at such events.
4. VENDOR is responsible for tabulation of data (e.g., member, provider and key stakeholder data) collected through the agreed upon methods.
5. VENDOR is responsible for evaluation and analysis of all data collected and synthesis with CalOptima Health clinical or other data, as well as other secondary source data to inform identification of key findings in the MHNA report and executive summary, of which will summarize findings and include recommendations.
6. VENDOR will provide all raw data to CalOptima Health.

D. Member Incentives
1. If applicable, VENDOR shall receive and secure member incentives (i.e., digital nonmonetary gift cards) from CalOptima Health. Distribute and track incentive to member upon receipt of completed survey (mailed, telephone, text and/or in-person completion).
   a. Establish a mechanism for safekeeping of the gift cards from loss, theft, or delivery to non-CalOptima Health Medi-Cal members. The mechanism for safekeeping of the gift cards shall be mutually agreed upon between VENDOR and CalOptima Health.
   b. Only use the gift cards consistent with this scope of work. A maximum of one incentive per survey respondent will be awarded and for participation in one focus group, if applicable.

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c. Coordinate with CalOptima Health staff to validate Medi-Cal eligibility and CalOptima Health membership prior to distributing the gift cards.
d. Return to CalOptima Health all gift cards that were not distributed to the designated CalOptima Health members, within thirty (30) calendar days of completion of all member surveys and focus groups.
e. VENDOR will establish an automated method to report to CalOptima Health following the delivery of the gift card, of which the minimum requirements include:
    i. The date of delivery or mailing and number of gift cards received by VENDOR from CalOptima Health.
    ii. A list of eligible members who received the gift card, including but not limited to member name, member CalOptima Health ID, and the date member participated in the survey or focus group.
    iii. Whether the gift card was hand delivered or mailed.
    iv. The number of gift cards remaining to be distributed.
f. VENDOR shall reasonably ensure use of the gift cards are solely used as contemplated in this Agreement and in compliance with DHCS requirements (gift cards is not to be used to purchase firearms, tobacco, alcohol, etc.). CalOptima Health retains the right to recover any gift card(s) or face value of such gift card(s) if it (or any of its regulators) determines that, as a result of VENDOR's negligence, the gift card(s) were not provided in accordance with (1) the terms of this Agreement; or (2) applicable federal and state laws, regulations, guidance and/or funding source requirement. This Section shall survive the termination of this Agreement.

E. Member Health Needs Assessment 2023 Report and Executive Summary
1. Once survey administration, data collection and analysis are finished, VENDOR will seek input and feedback from CalOptima Health executives, develop a draft written report, executive summary and final written report of findings and recommendations for CalOptima Health, and will present findings to the Board of Directors (the Board) in the form of a public presentation.
2. The executive summary and final report will be used for internal and external publication. The report shall include details on main issues that current CalOptima Health members encounter, the barriers to those issues, potential solutions and methods of prevention (if available). Additionally, the report shall include consideration(s) and recommendation(s) of newly identified populations, such as the justice-involved and foster care populations.

   The Board will be provided regular updates by CalOptima Health staff on the progress of the MHNA 2023 activities. CalOptima Health staff will share the draft written report with the Board and with the MHNA 2023 Committee for review and comment. If applicable, VENDOR will incorporate comments into the draft report to generate the final report, executive summary and presentation.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

10. Approve Actions Related to a Contract with the National Opinion Research Center to Conduct a Member and Population Health Needs Assessment

Contact

Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981

Recommended Actions

Pursuant to the result of a formal procurement process, authorize the Chief Executive Officer to execute a contract with the National Opinion Research Center for a one-year term effective March 14, 2025, to conduct a Member and Population Health Needs Assessment.

Background

Following CalOptima Health's approval of the Harder + Company contract to perform a refreshed Member Health Needs Assessment in 2023, new regulatory and accreditation requirements from the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA) impacted the activities CalOptima Health must perform related to population health assessments. This resulted in termination of the contract with Harder + Company to develop a new scope of work (SOW) and project approach.

On April 4, 2024, the Board authorized the reallocation of $1 million in unspent appropriated funds to conduct a refreshed Member and Population Health Needs Assessment (MPHNA). The Board approved a new SOW to include the new requirements along with the release of a request for proposal (RFP) to procure the services of a research consultant.

On June 24, 2024, CalOptima Health completed the RFP process and received a total of six (6) proposals. However, given the changes to DHCS requirements related to CalAIM and Community Reinvestment, staff further identified a need to understand community assets to ensure alignment and partnership opportunities in community development work and investment strategies. This resulted in extending the timeline to develop a comprehensive list of requirements for the RFP. The prior RFP was canceled on August 1, 2024, and a revised RFP was issued on December 9, 2024.

Discussion

The MPHNA RFP issued on December 9, 2024, requested services to:

1. Assess the whole-person health needs and preferences of CalOptima Health members;
2. Assess community assets to inform the development of health equity interventions and community investments;
3. Provide best practices to develop programs and strategic approaches that best serve all Orange County Medi-Cal members; and
4. Assist with developing the Medi-Cal Population Needs Assessment and the NCQA Health Plan Accreditation and Health Equity Accreditation member assessments.

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The SOW requested in the RFP included the following required deliverables:

1. Study design to identify, synthesize, and analyze all available data to assess member health and population needs.
2. Detailed project plan that outlines a timeline with duration of tasks and Consultant/Contractor resources and responsibilities.
3. Final survey instruments (*e.g.*, member, provider, key informant), focus group facilitation guides, presentations, and other relevant materials.
4. Member outreach and engagement activities in threshold languages as needed to support the approved study design.
5. Data set collected and synthesized through the conduct of the assessment study.
6. Health Equity Asset Maps (HEAM), digital mapping tools that provide clear and engaging visualizations and visual aids of community assets in Orange County.
7. Analysis highlighting key initiatives and projects in the community and their organizations, assessing potential alignment and partnership opportunities with CalOptima in community development work and investment strategies.
8. MPHNA and HEAM reports and executive summary presentations detailing assessment findings and recommendations.
9. Interactive dashboard for ongoing population needs assessment and heat asset mapping reporting.

The RFP closed on January 21, 2025, and CalOptima Health received a total of eleven (11) proposals. All proposals were reviewed by an evaluation committee of CalOptima Health staff based on the following criteria:

- Demonstrated understanding and knowledge of the population health needs of Medi-Cal, Medicare, Orange County, and vulnerable populations;
- Proposed study design and methodology;
- Demonstrated knowledge and experience with data collection and analysis;
- Demonstrated understanding of the importance and role of comprehensive assessment of member needs to inform targeted Medi-Cal Managed Care Plan interventions;
- Demonstrated experience with engaging members and conducting member outreach and/or focus groups;
- Demonstrated experience with health equity asset mapping to provide information about the strengths and resources of a community;
- Qualifications and experience of the proposer and proposed team;
- Proposed approach and schedule; and
- Differentiators of the project design.

Proposal

Upon completing the proposal evaluation process, the following scores were given to each applicant:

Name	Proposal Score	Rank
Health Management Associates (HMA)	88.2	1
National Opinion Research Center (NORC)	87.4	2
Charitable Ventures of Orange County, Inc	76.6	3
Advance OC	76.5	4
COPE Healthcare Consulting, Inc. dba COPE Solutions Academy	69.6	5
Eviset, Inc	68	6
Sellers, Dorsey & Associates, LLC	66.2	7
Orange County Asian and Pacific Islander Community Alliance, Inc	61.2	8
ZS Associates, Inc	59	9
Measurement Resource Company	48.2	10
ECG Management Consultants LLC	44.2	11

Final Score After Interviews

The evaluation committee extended interviews to the organizations with the top two highest-scoring proposals, with the following final scores given to the applicants:

Name	Final Score	Rank
National Opinion Research Center (NORC)	90.5	1
Health Management Associates (HMA)	82.5	2

Based on standard procurement processes and in accordance with CalOptima Health Policy GA.5002: Purchasing, the evaluation team identified the NORC as the vendor that best meets CalOptima Health needs.

The targeted effective date of the new contract with NORC will be March 14, 2025. The contract will be for a one (1)-year term with a one (1) year extension option, exercisable at CalOptima Health's sole discretion.

Fiscal Impact

The recommended action will not have an additional fiscal impact. A previous Board action on April 4, 2024, reallocated $1 million from the Board-approved initiative CalOptima Health 2023 MHNA to fund the 2024 MPHNA. This funding will be sufficient to cover the estimated one-year cost for the contract with NORC of $966,384.

Rationale for Recommendation

Based on the evaluation results of the eleven (11) proposals received, staff recommend contracting with NORC as the vendor that best meets CalOptima Health's objectives for conducting a MPHNA and Health Equity Mapping initiative.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action.
2. Previous Board Action February 2, 2023, "Authorize Contract with Vendor to Assist with Member Health Needs Assessment 2023 Activities."
3. Previous Board Action April 4, 2024, "Approve Actions Related to the 2024 CalOptima Health Member and Population Health Needs Assessment."

/s/ Michael Hunn *02/27/2025*
Authorized Signature **Date**

Attachment to the March 6, 2025 Board of Directors Meeting – Agenda Item 10

Attachment #1 Member and Population Health Needs Assessment Contract

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
The National Opinion Research Center (NORC)	55 East Monroe St, 30th Floor	Chicago	IL	60603

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CalOptima Health Board Action Agenda Referral

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

Report Item

14. Authorize Contract with Vendor to Assist with Member Health Needs Assessment 2023 Activities

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operations Officer, (714) 923 8834

Recommended Actions

1. Authorize Chief Executive Officer to execute a contract with Harder+Company Community Research, Inc. (Harder+Company) to assist with the Member Health Needs Assessment 2023 activities in an amount not to exceed $1,250,000; and
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $250,000 from existing reserves for the contract with Harder+Company.

Background

In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: (1) Same Day Treatment Authorizations; (2) Real-Time Claims Payments; and (3) Annual Assessments of Members' Social Determinants of Health. The Member Health Needs Assessment (MHNA) will provide the foundational data for CalOptima Health's annual social determinants of health assessment. On November 3, 2022, the CalOptima Health Board of Directors approved the scope of work and unbudgeted expenditures for the CalOptima Health 2023 MHNA. The MHNA will be utilized to inform strategic development (e.g., health equity, social drivers of health, homeless health, etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on specific needs of Orange County's Medi-Cal beneficiaries.

In selecting the recommended vendor, a request for proposal (RFP) process for consultant services was issued by CalOptima Health on November 8, 2022, and a total of two proposals were received. A proposal evaluation committee comprised of staff from the CalAIM, Office of the CEO, Strategic Development, and Vendor Management departments – plus an external subject matter expert reviewed the submitted proposals. The consultants were also interviewed by the evaluation committee. After the evaluation of proposals and the interviews, the proposal with the highest overall score was selected.

Vendor	Proposal Score	Interview Score	Combined Scores
Harder+Company	4.68	4.74	4.71
Advance OC	3.67	3.78	3.73

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Discussion
Staff recommends Harder+Company as the selected vendor due to completeness of its proposal, as well as its knowledge and experience in completing community health needs assessments with local organizations, health plans, and other public health care agencies. Harder+Company, along with its subcontractor, Social Science Research Center at California State University, Fullerton (CSUF), has in-depth experience and subject matter expertise in the development and administration of multiple survey tools and methods as well as data analysis and final reporting and recommendations. The Social Science Research Center (SSRC) at CSUF will assist Harder+Company in collecting the member survey and developing tools and support analysis. In addition, due to SSRC's local university setting and expertise, Harder+Company will work with staff to connect to local community-based organizations.

Harder+Company will assist staff with the activities associated with the 2023 MHNA, including (1) development of a best practice model project plan, (2) development of survey instruments and facilitation guides, (3) administration of member and provider/key informant surveys (mail/online, telephone, in-person and facilitation at community town halls/forums and focus groups), (4) data sampling, collection and analysis combined with evaluation of internally produced clinical/survey data and external secondary data sources, and (5) development of the final health needs assessment report and recommendations.

Fiscal Impact
A previous Board action on November 3, 2022, authorized and appropriated up to $1 million from existing reserves to fund the CalOptima Health 2023 MHNA. An appropriation of up to $250,000 from existing reserves will fund the unbudgeted shortfall amount to execute the contract with Harder+Company.

Rationale for Recommendation
The 2023 MHNA will support CalOptima Health's health equity and social drivers of health strategies to improve the overall health of CalOptima Health members. Harder+Company had the highest score from their proposal and interview. It also successfully assisted CalOptima Health with 2017-18 MHNA, as well as the evaluation of CalOptima Health's Shape Your Life Program in 2019.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Previous Board Action November 3, 2022, "Approve Actions Related to the CalOptima Health Member Needs Assessment 2023"

Board Action

Board Meeting Dates	Action	Not to Exceed Amount
November 3, 2022	Approve Actions Related to the CalOptima Health Member Needs Assessment 2023	Up to $1 million from existing reserves

/s/ Michael Hunn *01/26/2023*
Authorized Signature **Date**

Attachment to the February 2, 2023 Board of Directors Meeting – Agenda Item 14

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Harder + Company Community Research, Inc.	3965 5th Avenue, Suite 420	San Diego	CA	92103

CalOptima Health Board Action Agenda Referral

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

Report Item
8. Approve Actions Related to the CalOptima Health Member Health Needs Assessment 2023

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Government Affairs and Strategic Development, (657) 900-1096

Recommended Actions
1. Approve the scope of work (SOW) for the CalOptima Health 2023 Member Health Needs Assessment (MHNA) and release a request for proposal.
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $1 million from existing reserves for the CalOptima Health 2023 MHNA.

Background
In 2017-18, CalOptima Health conducted a comprehensive MHNA of approximately 5,800 members to identify the focused needs of Orange County's Medi-Cal beneficiaries – in particular, ethnic minorities and their health needs and interests. The results of the 2017-18 assessment highlighted key findings in the areas of social determinants of health, mental health, primary care, provider access, and dental care.

Assessments such as Population Needs Assessment, Health Effectiveness Data and Information Set (HEDIS) reports, and member satisfaction surveys are periodically conducted to identify the health risks, beliefs, and practices of CalOptima Health's Medi-Cal members. However, these assessments and surveys do not represent the full scope and depth of the health needs of CalOptima Health members. In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: 1) Same Day Treatment Authorizations; 2) Real-Time Claims Payments; and 3) Annual Assessments of Members' Social Determinants of Health. The MHNA will provide the foundational data for CalOptima Health's annual social determinants of health assessment.

Discussion
Given the inequities revealed through the COVID-19 pandemic and an increase in CalOptima Health's membership, staff recommends engaging the professional services of a research consultant to conduct another MHNA in Q1 2023. The MHNA will be an expanded version of the original assessment completed in 2017-18, surveying at least 10% of CalOptima Health's membership, to help CalOptima Health identify additional and/or confirm the needs of members, barriers to accessing care, gaps in services, and disparities in health among members and the general community.

The 2023 MHNA will assist CalOptima Health with:
- Implementing Department of Health Care Services population health strategies (e.g., population health management strategy, support health and opportunity for children and families,

comprehensive quality strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives.
- Improving member health outcomes by identifying opportunities and solutions of health care access specific to each ethnic community.
- Identifying and establishing opportunities for meaningful engagement and partnerships regarding health and well-being, especially for underserved and difficult-to-reach populations.
- Addressing health equity and influences of the social determinants of health.
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions.

Staff recommends that the Board authorize $1 million from existing reserves to conduct the 2023 MHNA as the results of the MHNA will be utilized to inform strategic initiative development (e.g., health equity, social determinants of health, homeless health etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on the specific needs of Orange County's Medi-Cal beneficiaries.

Fiscal Impact
The recommended action is unbudgeted. An appropriation of up to $1 million from existing reserves will fund this action.

Rationale for Recommendation
The recommended actions will support CalOptima Health's health equity and social determinants of health strategies to improve the overall health of CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed CalOptima Health Member Health Needs Assessment 2023 Scope of Work

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

SCOPE OF WORK
Member Needs Health Assessment 2023

I. OBJECTIVE

CalOptima Health is seeking to engage the professional services of a community research consultant with knowledge of multi-cultural populations and strategies for improved program engagement to conduct a comprehensive Member Health Needs Assessment (MHNA) 2023.

The MHNA 2023 will be an expanded version of the original assessment completed in 2017-18, ensuring a diverse group of at least 10% of CalOptima Health members at the time the survey is conducted are surveyed. Given the inequities revealed through the COVID-19 pandemic, the MHNA 2023 assessment will result in a final report that includes recommendations on how to address the needs of members and newly identified populations, barriers to access care, gaps in services and disparities in health among members. The project shall incorporate coordination and collaboration (as feasible) with external partners (e.g. Orange County Health Care Agency and Social Services Agency) to provide complementary information and avoid duplication of efforts to the extent possible.

The MHNA 2023 will assist CalOptima Health with:

- Implementing DHCS population health strategies (e.g., Population Health Management Strategy, Support Health and Opportunity for Children and Families, Comprehensive Quality Strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives
- Improving member health outcomes by identifying opportunities to improve health care access specific to each ethnic community
- Identifying and establishing opportunities for meaningful engagement with new partnering organizations regarding health and well-being, especially for underserved, difficult-to-reach and newly identified populations (increase capacity and extend services)
- Analyzing social determinants of health impacting CalOptima Health members and designing strategies, programs and interventions to address them (e.g., food and nutritional assistance, medically prescribed food boxes, linkages to housing support and other community and social support services, etc.)
- Identifying opportunities for partnership with social service type providers
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions
- Identifying and recommending unique services for new populations, such as the justice-involved and foster care populations

The anticipated launch date for this project is February 2023. A final report shall be prepared and presented to the Board by the fourth quarter of 2023.

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II. SCOPE OF WORK

1. PRODUCTS/SERVICES

A. Project Plan and Budget

1. Proposal project plans must clearly articulate VENDOR approach and address the following elements:
    a. Development of survey instruments and associated facilitation guides,
    b. Facilitation of in-person and/or virtual community town halls/forums and focus group meetings,
    c. Data collection and analysis,
    d. Development of draft report by the third quarter of 2023, executive summary, final report and presentation to the Board by the fourth quarter of 2023.
    e. Include detailed timeline with duration of tasks (by number of days) and VENDOR resources and responsibilities.
    f. Proposed number of survey collection to ensure results are statistically significant and representative of CalOptima Health members.
2. Proposal must include a detailed project budget and justifications based on proposed project plan, timeline, direct labor costs (including hourly rates), travel, subcontracts (if applicable), supplies/materials, etc.
3. Proposals must outline how VENDOR will safeguard and store member information and protected health information that may be obtained throughout the course of the project.

B. Survey Instruments and Facilitation Guides

1. VENDOR shall determine appropriate methodologies and resources to be used for development of the MHNA 2023 survey instruments, group facilitation guides and/or other assessment tools. VENDOR will provide recommendations and seek input from CalOptima Health staff and Committee on development and finalization of survey instruments, facilitation guides, presentations, etc.
2. The final survey instruments (e.g., member, provider, key informant) and facilitation guides may leverage information gathered by VENDOR, through focus groups, other CalOptima Health surveys and clinical data, other internal data collection efforts and external secondary data sources e.g. Advance OC 2020 Social Progress Index, the 27th Annual Report on the Conditions of Children in Orange County (Orange County Children's Partnership), 2021-2022 Orange County Community Indicators Report, 2022 Report on Aging in Orange County, (Orange County Strategic Plan for Aging), etc..

C. Survey Administration and Group Meeting Facilitation

1. VENDOR shall recommend the best practice of survey administration for members, such as: mailed and online surveys, telephone interviews, text messaging, in-person data collection components, etc.
    a. Mailed/online/text messaging member survey and telephone scripts will be translated into Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese (additional languages may be included depending on preliminary research findings) by CalOptima Health.

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b. If selected, telephone interviews are to be conducted by VENDOR, and must be conducted in English, Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese by VENDOR.
c. Provider surveys may be mailed and/or provided as an online survey option.
d. The VENDOR shall have enough trained, experienced interviewers capable to conduct the identified volume of interviews and other data collection activities in the identified languages.

2. CalOptima Health staff will work collaboratively with VENDOR to promote member surveys (if applicable) at:
   a. In-person and/or virtual community town halls/forums and focus groups,
   b. Community resource and health fair events,
   c. New member orientations,
   d. Health education seminars,
   e. Faith-based group meetings,
   f. Other events/activities as identified, etc.

   CalOptima Health staff can utilize existing community relationships to make introductions for the VENDOR to connect with these organizations. VENDOR shall coordinate the events.
3. CalOptima Health staff can provide VENDOR with points of contact to administer provider and community leader/key informant interviews (if applicable) either virtually and/or at:
   a. Provider offices,
   b. Network forums,
   c. Community organization offices, and
   d. Other locations where providers and community leaders/key informants congregate.

   VENDOR will lead group facilitation, data collection and distribution of nonmonetary gift cards (if applicable) at such events.
4. VENDOR is responsible for tabulation of data (e.g., member, provider and key stakeholder data) collected through the agreed upon methods.
5. VENDOR is responsible for evaluation and analysis of all data collected and synthesis with CalOptima Health clinical or other data, as well as other secondary source data to inform identification of key findings in the MHNA report and executive summary, of which will summarize findings and include recommendations.
6. VENDOR will provide all raw data to CalOptima Health.

D. Member Incentives
1. If applicable, VENDOR shall receive and secure member incentives (i.e., digital nonmonetary gift cards) from CalOptima Health. Distribute and track incentive to member upon receipt of completed survey (mailed, telephone, text and/or in-person completion).
   a. Establish a mechanism for safekeeping of the gift cards from loss, theft, or delivery to non-CalOptima Health Medi-Cal members. The mechanism for safekeeping of the gift cards shall be mutually agreed upon between VENDOR and CalOptima Health.
   b. Only use the gift cards consistent with this scope of work. A maximum of one incentive per survey respondent will be awarded and for participation in one focus group, if applicable.

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c. Coordinate with CalOptima Health staff to validate Medi-Cal eligibility and CalOptima Health membership prior to distributing the gift cards.
d. Return to CalOptima Health all gift cards that were not distributed to the designated CalOptima Health members, within thirty (30) calendar days of completion of all member surveys and focus groups.
e. VENDOR will establish an automated method to report to CalOptima Health following the delivery of the gift card, of which the minimum requirements include:
    i. The date of delivery or mailing and number of gift cards received by VENDOR from CalOptima Health.
    ii. A list of eligible members who received the gift card, including but not limited to member name, member CalOptima Health ID, and the date member participated in the survey or focus group.
    iii. Whether the gift card was hand delivered or mailed.
    iv. The number of gift cards remaining to be distributed.
f. VENDOR shall reasonably ensure use of the gift cards are solely used as contemplated in this Agreement and in compliance with DHCS requirements (gift cards is not to be used to purchase firearms, tobacco, alcohol, etc.). CalOptima Health retains the right to recover any gift card(s) or face value of such gift card(s) if it (or any of its regulators) determines that, as a result of VENDOR's negligence, the gift card(s) were not provided in accordance with (1) the terms of this Agreement; or (2) applicable federal and state laws, regulations, guidance and/or funding source requirement. This Section shall survive the termination of this Agreement.

E. Member Health Needs Assessment 2023 Report and Executive Summary
1. Once survey administration, data collection and analysis are finished, VENDOR will seek input and feedback from CalOptima Health executives, develop a draft written report, executive summary and final written report of findings and recommendations for CalOptima Health, and will present findings to the Board of Directors (the Board) in the form of a public presentation.
2. The executive summary and final report will be used for internal and external publication. The report shall include details on main issues that current CalOptima Health members encounter, the barriers to those issues, potential solutions and methods of prevention (if available). Additionally, the report shall include consideration(s) and recommendation(s) of newly identified populations, such as the justice-involved and foster care populations.

   The Board will be provided regular updates by CalOptima Health staff on the progress of the MHNA 2023 activities. CalOptima Health staff will share the draft written report with the Board and with the MHNA 2023 Committee for review and comment. If applicable, VENDOR will incorporate comments into the draft report to generate the final report, executive summary and presentation.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken April 4, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

16. Approve Actions Related to the 2024 CalOptima Health Member and Population Health Needs Assessment

Contact

Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981

Recommended Actions

1. Authorize reallocation of remaining unspent funds, approximately $1.0 million, from the Board-approved initiative CalOptima Health 2023 Member Health Needs Assessment (MHNA) to fund the 2024 Member and Population Health Needs Assessment (MPHNA).
2. Approve the scope of work (SOW) for the 2024 CalOptima Health MPHNA and release of a request for proposals (RFP).

Background

In 2018, CalOptima Health conducted a Member Health Needs Assessment (MHNA) to identify the focused needs of Orange County's Medi-Cal beneficiaries, in particular to assess the health needs and preferences of diverse populations. The results of the 2018 assessment highlighted key findings in the areas of:

- Social Determinants of Health,
- Mental Health,
- Primary Care,
- Provider Access, and
- Dental Care.

On November 3, 2022, the CalOptima Health Board of Directors (Board) approved $1 million from reserves to fund the CalOptima Health 2023 MHNA to conduct an expanded and refreshed assessment and to take into account the needs of members after the COVID-19 pandemic. CalOptima Health released an RFP for consultant services on November 8, 2022, and the evaluation committee selected Harder + Company Community Research (Harder + Company) to conduct the assessment. On February 2, 2023, the Board approved the contract with Harder + Company in an amount not to exceed $1,250,000 and appropriated up to $250,000 from reserves to fund the shortfall. The contract was to assess and support the following areas:

- Implementing Department of Health Care Services (DHCS) population health strategies (*e.g.*, population health management strategy, support health and opportunity for children and families, comprehensive quality strategy, etc.) and California Advancing and Innovating Medi-Cal (now referred to as Medi-Cal Transformation) initiatives.
- Improving member health outcomes by identifying opportunities and solutions of health care access specific to each ethnic community.

- Identifying and establishing opportunities for meaningful engagement and partnerships regarding health and well-being, especially for underserved and difficult-to-reach populations.
- Addressing health equity and influences of the social determinants of health.
- Highlighting inequities that have/were amplified by the COVID-19 pandemic and identifying sustainable solutions.

Following approval of the Harder + Company contract in 2023, new regulatory and accreditation requirements from DHCS and the National Committee for Quality Assurance (NCQA) impacted the activities CalOptima Health must perform related to population health assessments. As CalOptima Health began working with Harder + Company, CalOptima Health staff discovered that these new requirements were not accounted for in the Board approved SOW and contract. Based on the new changes to regulatory and accreditation requirements, CalOptima Health staff chose to end the Harder + Company contract in January 2024 and develop a new SOW and project approach.

Discussion

Given the changes to regulatory requirements under Medi-Cal Transformation and NCQA accreditation requirements, staff recommends Board approval of the new SOW and release of an RFP to procure the services of a research consultant with knowledge of Orange County's diverse populations and opportunities for meaningful outreach and engagement to conduct the 2024 MPHNA. The new MPHNA will be a more comprehensive assessment and will be expanded to help CalOptima Health assess whole-person health needs and identify additional barriers to access to care, gaps in services, and disparities in health among members and the general community. The 2024 MPHNA will utilize existing CalOptima Health member data, existing community data provided by the county Community Health Needs Assessment, and other sources of data. The 2024 MPHNA may also utilize a small member survey and member focus groups to obtain member input.

There is approximately $1.0 million in unspent funds available for reallocation after the termination of the Harder + Company contract. Staff recommends reallocation of the remaining funds to support the CalOptima Health 2024 MPHNA. If approved, CalOptima Health will issue an RFP for consultant services for the new SOW. Proposals received will be evaluated by an evaluation committee. Upon completion of the RFP process, staff will make a recommendation for selection of a vendor to the Board at a future Board meeting.

Fiscal Impact

Previous Board actions on November 3, 2022, and February 2, 2023, authorized $1.25 million to fund the CalOptima Health 2023 MHNA. The remaining unspent funds of approximately $1.0 million committed for this Board-approved initiative will fund the CalOptima Health 2024 MPHNA.

Rationale for Recommendation

Approving the recommended actions will allow CalOptima Health to move forward with a new SOW and obtain a contractor that can support all regulatory and accreditation requirements for member and population assessment.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Proposed CalOptima Health Member and Population Health Needs Assessment (MPHNA) 2024 Scope of Work.
2. Previous Board Action November 3, 2022, "Approve Actions Related to CalOptima Health Member Health Needs Assessment 2023."
3. Previous Board Action February 2, 2023, "Authorize Contract with Vendor to Assist with Member Health Needs Assessment 2023 Activities."

/s/ Michael Hunn *03/29/2024*
Authorized Signature **Date**

SCOPE OF WORK
CalOptima Health Member and Population Health Needs Assessment

I. OBJECTIVE

CalOptima Health is seeking a contractor to conduct a comprehensive Member and Population Health Needs Assessment (MPHNA). The purpose of the MPHNA is to:

1. Assess the whole-person health needs and preferences of CalOptima Health members.
2. Inform the development of programs and strategic approaches to best serve all Orange County Medi-Cal members.
3. Meet the member and population health needs assessment requirements of the Medi-Cal Population Needs Assessment (PNA) and the National Committee for Quality Assurance (NCQA) Health Plan Accreditation and Health Equity Accreditation member assessments.

II. SCOPE OF WORK

CalOptima Health seeks a contractor to provide professional research and analytical services that has detailed knowledge of Medi-Cal, Medicare, and Orange County populations. The contractor shall have demonstrated expertise and knowledge in analyzing population and member level data and producing detailed analyses and dashboards to present study findings. The contractor shall be able to analyze existing CalOptima Health and community data sources and also propose approaches to obtaining member, provider, and community input through interviews, surveys and/or focus groups.

Consulting services will be for the purpose of taking a strategic approach to consolidating related CalOptima Health efforts to assess population health data (including members and potential members) that meets deliverable requirements as outlined by the Department of Health Care Services (DHCS), NCQA, and other related requirements. These contracted services will inform and support CalOptima Health in achieving the following objectives:

- Meet the requirements of DHCS population health initiatives, e.g., Population Health Management Strategy, Population Needs Assessment (PNA), and Medi-Cal Transformation initiatives.
- Meet the requirements of NCQA Health Plan Accreditation PHM Standards, PHM 2, including Elements A (Data Integration), B (Population Assessment), and D (Segmentation).
- Meet the requirements of NCQA Health Equity Accreditation as applicable.
- Understand the detailed member and population needs of our member population and community, including in the domains outlined in this scope of work.

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- Understand member experience with CalOptima Health services and recommendations for future service offerings.
- Identify opportunities to advance health equity with our member population.

The MPHNA areas of assessment will include *but not be limited to* the attributes/domains of the CalOptima Health member population as outlined in the table below. CalOptima Health aims to assess these areas for our entire member population as well as for subsets of the member population, including child and adolescent members, members with disabilities, members with serious mental illness or serious emotional disturbance, members of racial or ethnic groups, members with limited English proficiency, and other relevant subpopulations.

Assessment Domain	Areas for Analysis
Demographics of Member Population	• Age • Race • Ethnicity • Language • Sexual Orientation • Gender Identity • Etc.
Health Status and Health Conditions	• Chronic conditions/disease prevalence (e.g., asthma, diabetes, chronic obstructive pulmonary disease, etc.) • Member risk profile • Births • High-risk pregnancy • Behavioral health conditions • Smoking • Substance use disorder • Disparities • Vaccination rates • Select Healthcare Effectiveness Data and Information Set (HEDIS) measures
Social Conditions	• Social determinants of health needs • Barriers to getting needed help • Barriers to economic mobility • Transportation challenges • Etc.
Health Equity	• Challenges with accessing care (e.g., language, health literacy, affinity with providers, etc.) • Challenges with accessing social supports • Member experience • Cultural preferences

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Assessment Domain	Areas for Analysis
Access to Care and Supports	• Barriers to accessing care and support (e.g., childcare, hours of operation, not enough information, unable to find a provider, no appointments available/delays in timely access, etc.) • Access to behavioral health services and barriers • Services most and least utilized • Unmet care needs • Eligibility loss/churn/income changes
CalOptima Health Services & Supports	• Experience with CalAIM services • Medicare supplemental benefits • Participation in other coverage programs • How CalOptima Health partners in their communities

The project shall incorporate coordination and collaboration with CalOptima Health and external partners (e.g., Orange County Health Care Agency and Social Services Agency) to provide complementary information and avoid duplication of efforts to the extent possible.

III. CONSULTANT/CONTRACTOR'S RESPONSIBILITIES

Consultant/Contractor shall:

1. Develop a study design to identify, synthesize, and analyze all available data to assess member health and population needs, including but not limited to:
    a. CalOptima Health internal data
    b. Additional data sources, i.e., the county Community Health Needs Assessment, etc.
    c. Member input through a small-scale member survey to fill gaps in existing data, focus groups, etc.
    d. Community input
    e. Provider input

    The Study design must outline study methodologies, data sources, and data collection methods. The study design must be presented to CalOptima Health for review and input prior to finalization. It will also be presented to the CalOptima Health Member and Provider Advisory Committee and potentially other community forums for comment.

2. Develop a detailed project plan that outlines a timeline with duration of tasks and Consultant/Contractor resources and responsibilities. The timeline should be developed in partnership with CalOptima Health staff to account for regulatory approval timelines where necessary. The project plan must be updated throughout the project if timelines change.

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3. Develop MPHNA deliverables that will be presented to CalOptima Health for review and approval, including if applicable:
    a. Final survey instruments (e.g., member, provider, key informant)
    b. Focus group facilitation guides, presentations, and other relevant materials
    c. Outreach and engagement materials for member communication and community organization communication

    All member facing materials must be translated in all threshold languages. All member facing materials must also be submitted for review to CalOptima Health. CalOptima Health may be required to submit certain materials to the Department of Health Care Services for review and approval, and timelines should be constructed to allow such approval time.

4. Facilitate member outreach and engagement activities in threshold languages in partnership with CalOptima Health and community organizations (e.g. member incentives, focus groups, community, or member forums, etc.) as needed to support the approved study design.

5. Provide interim assessment deliverables for NCQA filings if needed. These interim deliverables may include a preliminary assessment of internal and secondary data sources and obtaining member input from existing member committees and forums.

6. Develop final MPHNA report and executive summary presentation to CalOptima Health and its leadership detailing assessment findings and recommendations.

7. Produce dashboard for member assessment that can be utilized by CalOptima Health staff and stakeholders for ongoing population needs assessment reporting.

8. Deliver data set collected and synthesized through the conduct of the assessment study.

9. Schedule and conduct regular meetings with CalOptima Health staff to present relevant findings and project status.

10. Present MPHNA findings to the CalOptima Health Board of Directors.

The Consultant/Contractor must perform all work according to industry and professional standards and in a manner satisfactory to CalOptima Health and, if applicable, regulatory and accreditation requirements.

The Consultant/Contractor may propose to utilize subcontracted services for survey administration and/or focus group facilitation to ensure alignment of skills with services. The Consultant/Contractor is responsible for ensuring that performance and completion of project deliverables by any and all subcontractors align with the responsibilities outlined in this scope of work.

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IV. CALOPTIMA HEALTH'S RESPONSIBILITIES

CalOptima Health staff shall:

1. Provide a point of contact and meet regularly with the Consultant/Contractor to discuss project status, open questions, and deliverable development.
2. Provide documentation on requirements for Consultant/Contractor to review and key resources and department point of contacts.
3. Provide guidance on regulatory and CalOptima Health's requirements.
4. Work collaboratively with Consultant/Contractor to promote member and provider surveys, if included in the study design.
5. Provide and distribute Member Incentives (if applicable).
6. Utilize existing community relationships to make introductions for the Consultant/Contractor to connect with these organizations.
7. Facilitate CalOptima Health internal approvals and DHCS regulatory approvals as needed.
8. Provide Consultant/Contractor with points of contact to administer community leader/key informant and provider interviews (if applicable).

V. TIMELINES

This contract will continue through the completion of deliverables outlined in the Scope of Work, with a framework that can be leveraged for annual refreshing on a go-forward basis of the MPHNA to meet NCQA requirements. Consultant/Contractor shall:

1. Begin project planning in July 2024, with implementation through December 2024.
2. On an ongoing basis, meet regularly with CalOptima Health to assess progress and opportunities and share findings with CalOptima Health.

VI. PRICING

The Consultant/Contractor should propose a budget and pricing for this project.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

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

Report Item
8. Approve Actions Related to the CalOptima Health Member Health Needs Assessment 2023

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Government Affairs and Strategic Development, (657) 900-1096

Recommended Actions
1. Approve the scope of work (SOW) for the CalOptima Health 2023 Member Health Needs Assessment (MHNA) and release a request for proposal.
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $1 million from existing reserves for the CalOptima Health 2023 MHNA.

Background
In 2017-18, CalOptima Health conducted a comprehensive MHNA of approximately 5,800 members to identify the focused needs of Orange County's Medi-Cal beneficiaries – in particular, ethnic minorities and their health needs and interests. The results of the 2017-18 assessment highlighted key findings in the areas of social determinants of health, mental health, primary care, provider access, and dental care.

Assessments such as Population Needs Assessment, Health Effectiveness Data and Information Set (HEDIS) reports, and member satisfaction surveys are periodically conducted to identify the health risks, beliefs, and practices of CalOptima Health's Medi-Cal members. However, these assessments and surveys do not represent the full scope and depth of the health needs of CalOptima Health members. In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: 1) Same Day Treatment Authorizations; 2) Real-Time Claims Payments; and 3) Annual Assessments of Members' Social Determinants of Health. The MHNA will provide the foundational data for CalOptima Health's annual social determinants of health assessment.

Discussion
Given the inequities revealed through the COVID-19 pandemic and an increase in CalOptima Health's membership, staff recommends engaging the professional services of a research consultant to conduct another MHNA in Q1 2023. The MHNA will be an expanded version of the original assessment completed in 2017-18, surveying at least 10% of CalOptima Health's membership, to help CalOptima Health identify additional and/or confirm the needs of members, barriers to accessing care, gaps in services, and disparities in health among members and the general community.

The 2023 MHNA will assist CalOptima Health with:
- Implementing Department of Health Care Services population health strategies (e.g., population health management strategy, support health and opportunity for children and families,

comprehensive quality strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives.
- Improving member health outcomes by identifying opportunities and solutions of health care access specific to each ethnic community.
- Identifying and establishing opportunities for meaningful engagement and partnerships regarding health and well-being, especially for underserved and difficult-to-reach populations.
- Addressing health equity and influences of the social determinants of health.
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions.

Staff recommends that the Board authorize $1 million from existing reserves to conduct the 2023 MHNA as the results of the MHNA will be utilized to inform strategic initiative development (e.g., health equity, social determinants of health, homeless health etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on the specific needs of Orange County's Medi-Cal beneficiaries.

Fiscal Impact
The recommended action is unbudgeted. An appropriation of up to $1 million from existing reserves will fund this action.

Rationale for Recommendation
The recommended actions will support CalOptima Health's health equity and social determinants of health strategies to improve the overall health of CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed CalOptima Health Member Health Needs Assessment 2023 Scope of Work

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

SCOPE OF WORK
Member Needs Health Assessment 2023

I. OBJECTIVE

CalOptima Health is seeking to engage the professional services of a community research consultant with knowledge of multi-cultural populations and strategies for improved program engagement to conduct a comprehensive Member Health Needs Assessment (MHNA) 2023.

The MHNA 2023 will be an expanded version of the original assessment completed in 2017-18, ensuring a diverse group of at least 10% of CalOptima Health members at the time the survey is conducted are surveyed. Given the inequities revealed through the COVID-19 pandemic, the MHNA 2023 assessment will result in a final report that includes recommendations on how to address the needs of members and newly identified populations, barriers to access care, gaps in services and disparities in health among members. The project shall incorporate coordination and collaboration (as feasible) with external partners (e.g. Orange County Health Care Agency and Social Services Agency) to provide complementary information and avoid duplication of efforts to the extent possible.

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- Analyzing social determinants of health impacting CalOptima Health members and designing strategies, programs and interventions to address them (e.g., food and nutritional assistance, medically prescribed food boxes, linkages to housing support and other community and social support services, etc.)
- Identifying opportunities for partnership with social service type providers
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions
- Identifying and recommending unique services for new populations, such as the justice-involved and foster care populations

The anticipated launch date for this project is February 2023. A final report shall be prepared and presented to the Board by the fourth quarter of 2023.

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II. SCOPE OF WORK

1. PRODUCTS/SERVICES

A. Project Plan and Budget

1. Proposal project plans must clearly articulate VENDOR approach and address the following elements:
    a. Development of survey instruments and associated facilitation guides,
    b. Facilitation of in-person and/or virtual community town halls/forums and focus group meetings,
    c. Data collection and analysis,
    d. Development of draft report by the third quarter of 2023, executive summary, final report and presentation to the Board by the fourth quarter of 2023.
    e. Include detailed timeline with duration of tasks (by number of days) and VENDOR resources and responsibilities.
    f. Proposed number of survey collection to ensure results are statistically significant and representative of CalOptima Health members.
2. Proposal must include a detailed project budget and justifications based on proposed project plan, timeline, direct labor costs (including hourly rates), travel, subcontracts (if applicable), supplies/materials, etc.
3. Proposals must outline how VENDOR will safeguard and store member information and protected health information that may be obtained throughout the course of the project.

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2. The final survey instruments (e.g., member, provider, key informant) and facilitation guides may leverage information gathered by VENDOR, through focus groups, other CalOptima Health surveys and clinical data, other internal data collection efforts and external secondary data sources e.g. Advance OC 2020 Social Progress Index, the 27th Annual Report on the Conditions of Children in Orange County (Orange County Children's Partnership), 2021-2022 Orange County Community Indicators Report, 2022 Report on Aging in Orange County, (Orange County Strategic Plan for Aging), etc..

C. Survey Administration and Group Meeting Facilitation

1. VENDOR shall recommend the best practice of survey administration for members, such as: mailed and online surveys, telephone interviews, text messaging, in-person data collection components, etc.
    a. Mailed/online/text messaging member survey and telephone scripts will be translated into Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese (additional languages may be included depending on preliminary research findings) by CalOptima Health.

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b. If selected, telephone interviews are to be conducted by VENDOR, and must be conducted in English, Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese by VENDOR.
c. Provider surveys may be mailed and/or provided as an online survey option.
d. The VENDOR shall have enough trained, experienced interviewers capable to conduct the identified volume of interviews and other data collection activities in the identified languages.

2. CalOptima Health staff will work collaboratively with VENDOR to promote member surveys (if applicable) at:
   a. In-person and/or virtual community town halls/forums and focus groups,
   b. Community resource and health fair events,
   c. New member orientations,
   d. Health education seminars,
   e. Faith-based group meetings,
   f. Other events/activities as identified, etc.

   CalOptima Health staff can utilize existing community relationships to make introductions for the VENDOR to connect with these organizations. VENDOR shall coordinate the events.
3. CalOptima Health staff can provide VENDOR with points of contact to administer provider and community leader/key informant interviews (if applicable) either virtually and/or at:
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   b. Network forums,
   c. Community organization offices, and
   d. Other locations where providers and community leaders/key informants congregate.

   VENDOR will lead group facilitation, data collection and distribution of nonmonetary gift cards (if applicable) at such events.
4. VENDOR is responsible for tabulation of data (e.g., member, provider and key stakeholder data) collected through the agreed upon methods.
5. VENDOR is responsible for evaluation and analysis of all data collected and synthesis with CalOptima Health clinical or other data, as well as other secondary source data to inform identification of key findings in the MHNA report and executive summary, of which will summarize findings and include recommendations.
6. VENDOR will provide all raw data to CalOptima Health.

D. Member Incentives
1. If applicable, VENDOR shall receive and secure member incentives (i.e., digital nonmonetary gift cards) from CalOptima Health. Distribute and track incentive to member upon receipt of completed survey (mailed, telephone, text and/or in-person completion).
   a. Establish a mechanism for safekeeping of the gift cards from loss, theft, or delivery to non-CalOptima Health Medi-Cal members. The mechanism for safekeeping of the gift cards shall be mutually agreed upon between VENDOR and CalOptima Health.
   b. Only use the gift cards consistent with this scope of work. A maximum of one incentive per survey respondent will be awarded and for participation in one focus group, if applicable.

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c. Coordinate with CalOptima Health staff to validate Medi-Cal eligibility and CalOptima Health membership prior to distributing the gift cards.
d. Return to CalOptima Health all gift cards that were not distributed to the designated CalOptima Health members, within thirty (30) calendar days of completion of all member surveys and focus groups.
e. VENDOR will establish an automated method to report to CalOptima Health following the delivery of the gift card, of which the minimum requirements include:
    i. The date of delivery or mailing and number of gift cards received by VENDOR from CalOptima Health.
    ii. A list of eligible members who received the gift card, including but not limited to member name, member CalOptima Health ID, and the date member participated in the survey or focus group.
    iii. Whether the gift card was hand delivered or mailed.
    iv. The number of gift cards remaining to be distributed.
f. VENDOR shall reasonably ensure use of the gift cards are solely used as contemplated in this Agreement and in compliance with DHCS requirements (gift cards is not to be used to purchase firearms, tobacco, alcohol, etc.). CalOptima Health retains the right to recover any gift card(s) or face value of such gift card(s) if it (or any of its regulators) determines that, as a result of VENDOR's negligence, the gift card(s) were not provided in accordance with (1) the terms of this Agreement; or (2) applicable federal and state laws, regulations, guidance and/or funding source requirement. This Section shall survive the termination of this Agreement.

E. Member Health Needs Assessment 2023 Report and Executive Summary
1. Once survey administration, data collection and analysis are finished, VENDOR will seek input and feedback from CalOptima Health executives, develop a draft written report, executive summary and final written report of findings and recommendations for CalOptima Health, and will present findings to the Board of Directors (the Board) in the form of a public presentation.
2. The executive summary and final report will be used for internal and external publication. The report shall include details on main issues that current CalOptima Health members encounter, the barriers to those issues, potential solutions and methods of prevention (if available). Additionally, the report shall include consideration(s) and recommendation(s) of newly identified populations, such as the justice-involved and foster care populations.

   The Board will be provided regular updates by CalOptima Health staff on the progress of the MHNA 2023 activities. CalOptima Health staff will share the draft written report with the Board and with the MHNA 2023 Committee for review and comment. If applicable, VENDOR will incorporate comments into the draft report to generate the final report, executive summary and presentation.

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CalOptima Health Board Action Agenda Referral

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

Report Item

14. Authorize Contract with Vendor to Assist with Member Health Needs Assessment 2023 Activities

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operations Officer, (714) 923 8834

Recommended Actions

1. Authorize Chief Executive Officer to execute a contract with Harder+Company Community Research, Inc. (Harder+Company) to assist with the Member Health Needs Assessment 2023 activities in an amount not to exceed $1,250,000; and
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $250,000 from existing reserves for the contract with Harder+Company.

Background

In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: (1) Same Day Treatment Authorizations; (2) Real-Time Claims Payments; and (3) Annual Assessments of Members' Social Determinants of Health. The Member Health Needs Assessment (MHNA) will provide the foundational data for CalOptima Health's annual social determinants of health assessment. On November 3, 2022, the CalOptima Health Board of Directors approved the scope of work and unbudgeted expenditures for the CalOptima Health 2023 MHNA. The MHNA will be utilized to inform strategic development (e.g., health equity, social drivers of health, homeless health, etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on specific needs of Orange County's Medi-Cal beneficiaries.

In selecting the recommended vendor, a request for proposal (RFP) process for consultant services was issued by CalOptima Health on November 8, 2022, and a total of two proposals were received. A proposal evaluation committee comprised of staff from the CalAIM, Office of the CEO, Strategic Development, and Vendor Management departments – plus an external subject matter expert reviewed the submitted proposals. The consultants were also interviewed by the evaluation committee. After the evaluation of proposals and the interviews, the proposal with the highest overall score was selected.

Vendor	Proposal Score	Interview Score	Combined Scores
Harder+Company	4.68	4.74	4.71
Advance OC	3.67	3.78	3.73

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Discussion
Staff recommends Harder+Company as the selected vendor due to completeness of its proposal, as well as its knowledge and experience in completing community health needs assessments with local organizations, health plans, and other public health care agencies. Harder+Company, along with its subcontractor, Social Science Research Center at California State University, Fullerton (CSUF), has in-depth experience and subject matter expertise in the development and administration of multiple survey tools and methods as well as data analysis and final reporting and recommendations. The Social Science Research Center (SSRC) at CSUF will assist Harder+Company in collecting the member survey and developing tools and support analysis. In addition, due to SSRC's local university setting and expertise, Harder+Company will work with staff to connect to local community-based organizations.

Harder+Company will assist staff with the activities associated with the 2023 MHNA, including (1) development of a best practice model project plan, (2) development of survey instruments and facilitation guides, (3) administration of member and provider/key informant surveys (mail/online, telephone, in-person and facilitation at community town halls/forums and focus groups), (4) data sampling, collection and analysis combined with evaluation of internally produced clinical/survey data and external secondary data sources, and (5) development of the final health needs assessment report and recommendations.

Fiscal Impact
A previous Board action on November 3, 2022, authorized and appropriated up to $1 million from existing reserves to fund the CalOptima Health 2023 MHNA. An appropriation of up to $250,000 from existing reserves will fund the unbudgeted shortfall amount to execute the contract with Harder+Company.

Rationale for Recommendation
The 2023 MHNA will support CalOptima Health's health equity and social drivers of health strategies to improve the overall health of CalOptima Health members. Harder+Company had the highest score from their proposal and interview. It also successfully assisted CalOptima Health with 2017-18 MHNA, as well as the evaluation of CalOptima Health's Shape Your Life Program in 2019.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Previous Board Action November 3, 2022, "Approve Actions Related to the CalOptima Health Member Needs Assessment 2023"

Board Action

Board Meeting Dates	Action	Not to Exceed Amount
November 3, 2022	Approve Actions Related to the CalOptima Health Member Needs Assessment 2023	Up to $1 million from existing reserves

/s/ Michael Hunn *01/26/2023*
Authorized Signature **Date**

Attachment to the February 2, 2023 Board of Directors Meeting – Agenda Item 14

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Harder + Company Community Research, Inc.	3965 5th Avenue, Suite 420	San Diego	CA	92103

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CalOptima Health Board Action Agenda Referral

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

Report Item

8. Approve Actions Related to the CalOptima Health Member Health Needs Assessment 2023

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Government Affairs and Strategic Development, (657) 900-1096

Recommended Actions

1. Approve the scope of work (SOW) for the CalOptima Health 2023 Member Health Needs Assessment (MHNA) and release a request for proposal.
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $1 million from existing reserves for the CalOptima Health 2023 MHNA.

Background

In 2017-18, CalOptima Health conducted a comprehensive MHNA of approximately 5,800 members to identify the focused needs of Orange County's Medi-Cal beneficiaries – in particular, ethnic minorities and their health needs and interests. The results of the 2017-18 assessment highlighted key findings in the areas of social determinants of health, mental health, primary care, provider access, and dental care.

Assessments such as Population Needs Assessment, Health Effectiveness Data and Information Set (HEDIS) reports, and member satisfaction surveys are periodically conducted to identify the health risks, beliefs, and practices of CalOptima Health's Medi-Cal members. However, these assessments and surveys do not represent the full scope and depth of the health needs of CalOptima Health members. In March of 2022, the Board of Directors adopted a new mission and vision statement. The new vision statement sets the following goals for the agency to be achieved by 2027: 1) Same Day Treatment Authorizations; 2) Real-Time Claims Payments; and 3) Annual Assessments of Members' Social Determinants of Health. The MHNA will provide the foundational data for CalOptima Health's annual social determinants of health assessment.

Discussion

Given the inequities revealed through the COVID-19 pandemic and an increase in CalOptima Health's membership, staff recommends engaging the professional services of a research consultant to conduct another MHNA in Q1 2023. The MHNA will be an expanded version of the original assessment completed in 2017-18, surveying at least 10% of CalOptima Health's membership, to help CalOptima Health identify additional and/or confirm the needs of members, barriers to accessing care, gaps in services, and disparities in health among members and the general community.

The 2023 MHNA will assist CalOptima Health with:

- Implementing Department of Health Care Services population health strategies (e.g., population health management strategy, support health and opportunity for children and families,

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comprehensive quality strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives.
- Improving member health outcomes by identifying opportunities and solutions of health care access specific to each ethnic community.
- Identifying and establishing opportunities for meaningful engagement and partnerships regarding health and well-being, especially for underserved and difficult-to-reach populations.
- Addressing health equity and influences of the social determinants of health.
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions.

Staff recommends that the Board authorize $1 million from existing reserves to conduct the 2023 MHNA as the results of the MHNA will be utilized to inform strategic initiative development (e.g., health equity, social determinants of health, homeless health etc.), future strategic planning efforts, and targeted program development and to support opportunities for meaningful engagement to improve the overall health of CalOptima Health members. The results may also guide service providers, community agencies, County of Orange departments, and policy makers on the specific needs of Orange County's Medi-Cal beneficiaries.

Fiscal Impact
The recommended action is unbudgeted. An appropriation of up to $1 million from existing reserves will fund this action.

Rationale for Recommendation
The recommended actions will support CalOptima Health's health equity and social determinants of health strategies to improve the overall health of CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed CalOptima Health Member Health Needs Assessment 2023 Scope of Work

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

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SCOPE OF WORK
Member Needs Health Assessment 2023

I. OBJECTIVE

CalOptima Health is seeking to engage the professional services of a community research consultant with knowledge of multi-cultural populations and strategies for improved program engagement to conduct a comprehensive Member Health Needs Assessment (MHNA) 2023.

The MHNA 2023 will be an expanded version of the original assessment completed in 2017-18, ensuring a diverse group of at least 10% of CalOptima Health members at the time the survey is conducted are surveyed. Given the inequities revealed through the COVID-19 pandemic, the MHNA 2023 assessment will result in a final report that includes recommendations on how to address the needs of members and newly identified populations, barriers to access care, gaps in services and disparities in health among members. The project shall incorporate coordination and collaboration (as feasible) with external partners (e.g. Orange County Health Care Agency and Social Services Agency) to provide complementary information and avoid duplication of efforts to the extent possible.

The MHNA 2023 will assist CalOptima Health with:

- Implementing DHCS population health strategies (e.g., Population Health Management Strategy, Support Health and Opportunity for Children and Families, Comprehensive Quality Strategy, etc.) and California Advancing and Innovating Medi-Cal (CalAIM) initiatives
- Improving member health outcomes by identifying opportunities to improve health care access specific to each ethnic community
- Identifying and establishing opportunities for meaningful engagement with new partnering organizations regarding health and well-being, especially for underserved, difficult-to-reach and newly identified populations (increase capacity and extend services)
- Analyzing social determinants of health impacting CalOptima Health members and designing strategies, programs and interventions to address them (e.g., food and nutritional assistance, medically prescribed food boxes, linkages to housing support and other community and social support services, etc.)
- Identifying opportunities for partnership with social service type providers
- Highlighting inequities that have/were amplified by COVD-19 pandemic and identify sustainable solutions
- Identifying and recommending unique services for new populations, such as the justice-involved and foster care populations

The anticipated launch date for this project is February 2023. A final report shall be prepared and presented to the Board by the fourth quarter of 2023.

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II. SCOPE OF WORK

1. PRODUCTS/SERVICES

A. Project Plan and Budget

1. Proposal project plans must clearly articulate VENDOR approach and address the following elements:
    a. Development of survey instruments and associated facilitation guides,
    b. Facilitation of in-person and/or virtual community town halls/forums and focus group meetings,
    c. Data collection and analysis,
    d. Development of draft report by the third quarter of 2023, executive summary, final report and presentation to the Board by the fourth quarter of 2023.
    e. Include detailed timeline with duration of tasks (by number of days) and VENDOR resources and responsibilities.
    f. Proposed number of survey collection to ensure results are statistically significant and representative of CalOptima Health members.
2. Proposal must include a detailed project budget and justifications based on proposed project plan, timeline, direct labor costs (including hourly rates), travel, subcontracts (if applicable), supplies/materials, etc.
3. Proposals must outline how VENDOR will safeguard and store member information and protected health information that may be obtained throughout the course of the project.

B. Survey Instruments and Facilitation Guides

1. VENDOR shall determine appropriate methodologies and resources to be used for development of the MHNA 2023 survey instruments, group facilitation guides and/or other assessment tools. VENDOR will provide recommendations and seek input from CalOptima Health staff and Committee on development and finalization of survey instruments, facilitation guides, presentations, etc.
2. The final survey instruments (e.g., member, provider, key informant) and facilitation guides may leverage information gathered by VENDOR, through focus groups, other CalOptima Health surveys and clinical data, other internal data collection efforts and external secondary data sources e.g. Advance OC 2020 Social Progress Index, the 27th Annual Report on the Conditions of Children in Orange County (Orange County Children's Partnership), 2021-2022 Orange County Community Indicators Report, 2022 Report on Aging in Orange County, (Orange County Strategic Plan for Aging), etc..

C. Survey Administration and Group Meeting Facilitation

1. VENDOR shall recommend the best practice of survey administration for members, such as: mailed and online surveys, telephone interviews, text messaging, in-person data collection components, etc.
    a. Mailed/online/text messaging member survey and telephone scripts will be translated into Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese (additional languages may be included depending on preliminary research findings) by CalOptima Health.

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b. If selected, telephone interviews are to be conducted by VENDOR, and must be conducted in English, Spanish, Vietnamese, Korean, Farsi, Arabic and Chinese by VENDOR.
c. Provider surveys may be mailed and/or provided as an online survey option.
d. The VENDOR shall have enough trained, experienced interviewers capable to conduct the identified volume of interviews and other data collection activities in the identified languages.

2. CalOptima Health staff will work collaboratively with VENDOR to promote member surveys (if applicable) at:
   a. In-person and/or virtual community town halls/forums and focus groups,
   b. Community resource and health fair events,
   c. New member orientations,
   d. Health education seminars,
   e. Faith-based group meetings,
   f. Other events/activities as identified, etc.

   CalOptima Health staff can utilize existing community relationships to make introductions for the VENDOR to connect with these organizations. VENDOR shall coordinate the events.
3. CalOptima Health staff can provide VENDOR with points of contact to administer provider and community leader/key informant interviews (if applicable) either virtually and/or at:
   a. Provider offices,
   b. Network forums,
   c. Community organization offices, and
   d. Other locations where providers and community leaders/key informants congregate.

   VENDOR will lead group facilitation, data collection and distribution of nonmonetary gift cards (if applicable) at such events.
4. VENDOR is responsible for tabulation of data (e.g., member, provider and key stakeholder data) collected through the agreed upon methods.
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c. Coordinate with CalOptima Health staff to validate Medi-Cal eligibility and CalOptima Health membership prior to distributing the gift cards.
d. Return to CalOptima Health all gift cards that were not distributed to the designated CalOptima Health members, within thirty (30) calendar days of completion of all member surveys and focus groups.
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    i. The date of delivery or mailing and number of gift cards received by VENDOR from CalOptima Health.
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2. The executive summary and final report will be used for internal and external publication. The report shall include details on main issues that current CalOptima Health members encounter, the barriers to those issues, potential solutions and methods of prevention (if available). Additionally, the report shall include consideration(s) and recommendation(s) of newly identified populations, such as the justice-involved and foster care populations.

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Financial Summary
October 31, 2025

Board of Directors Meeting

December 4, 2025

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

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

Financial Highlights Notes: October 2025

- Notable events/items in October 2025
  - Consolidated enrollment as of October 31, 2025, is 877,802 members, a decrease of 7,512 from Prior Month (PM), primarily due to the impacts of redetermination activities. The variance between actual and budget widened to -16,549 or -1.9%.
  - A new "Actual v. Budget – Total Membership" trend analysis chart has been added to this month's Financial Summary package.

CalOptima Health

Financial Highlights
October 2025

October 2025					July - October 2025			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
877,802	894,351	(16,549)	(1.9%)	Member Months	3,559,206	3,602,436	(43,230)	(1.2%)
391,534,915	393,262,363	(1,727,448)	(0.4%)	Revenues	1,812,045,480	1,585,363,351	226,682,129	14.3%
364,202,932	370,044,385	5,841,453	1.6%	Medical Expenses	1,663,728,422	1,473,709,557	(190,018,865)	(12.9%)
21,603,398	25,771,359	4,167,961	16.2%	Administrative Expenses	85,454,289	101,342,952	15,888,662	15.7%
5,728,585	(2,553,381)	**8,281,966**	**324.4%**	**Operating Margin**	**62,862,769**	**10,310,842**	**52,551,927**	**509.7%**
				Non-Operating Income (Loss)				
12,922,471	8,333,340	4,589,131	55.1%	Net Investment Income/Expense	59,447,383	33,333,360	26,114,023	78.3%
(1,002,221)	-	(1,002,221)	(100.0%)	Grant Expense	(1,459,767)	-	(1,459,767)	(100.0%)
(2,112,864)	-	(2,112,864)	(100.0%)	Community Reinvestment	(17,837,375)	-	(17,837,375)	(100.0%)
72,617	(138,610)	211,227	152.4%	Other Income/Expense	(265,760)	(554,440)	288,680	52.1%
9,880,003	**8,194,730**	**1,685,273**	**20.6%**	**Total Non-Operating Income (Loss)**	**39,884,481**	**32,778,920**	**7,105,561**	**21.7%**
15,608,588	**5,641,349**	**9,967,239**	**176.7%**	**Change in Net Assets**	**102,747,250**	**43,089,762**	**59,657,488**	**138.4%**
93.0%	*94.1%*	(1.1%)		*Medical Loss Ratio*	*91.8%*	*93.0%*	(1.1%)	
5.5%	*6.6%*	*1.0%*		*Administrative Loss Ratio*	*4.7%*	*6.4%*	*1.7%*	
1.5%	(0.6%)	*2.1%*		*Operating Margin Ratio*	*3.5%*	*0.7%*	*2.8%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
88.5%	*89.6%*	(1.1%)		**Adjusted MLR*	*86.3%*	*88.5%*	(2.3%)	
5.5%	*6.6%*	*1.0%*		**Adjusted ALR*	*5.4%*	*6.4%*	*1.0%*	

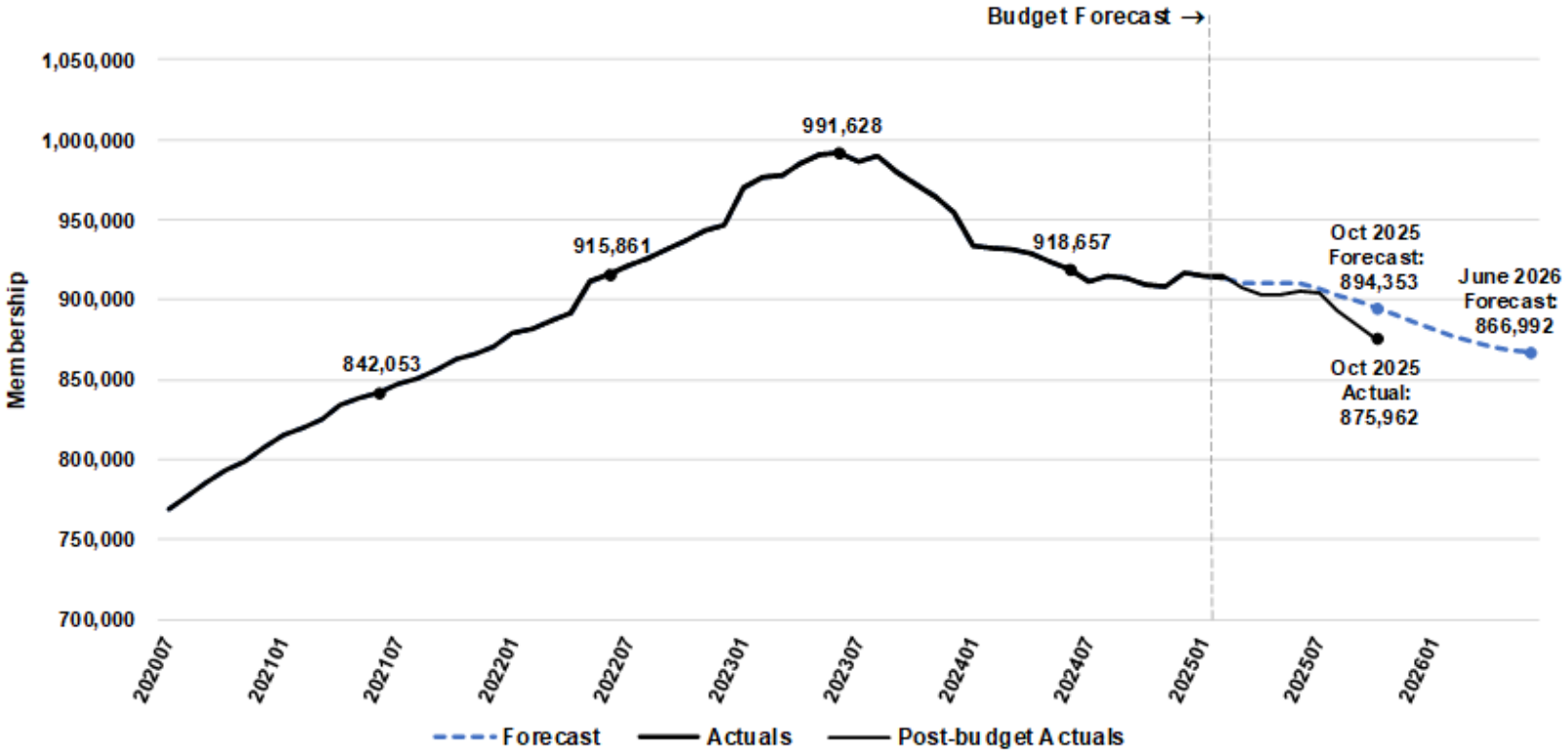
*Adjusted MLR/ALR excludes estimated Board-approved Provider Rate increases and Directed Payments, but includes costs associated with CalOptima Health's Digital Transformation Strategy (DTS) budget

CalOptima Health

Actual v. Budget – Total Membership

CalOptima Health

Consolidated



Notes:

- Data included in this report are based on member eligibility months rather than booked enrollment (as used in the financials).

CalOptima Health

FY 2025-26: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) October 2025: $15.6 million, favorable to budget $10.0 million or 176.7% driven by Net Investment Income and lower claims utilization
  - Year To Date (YTD) July – October 2025: $102.7 million, favorable to budget $59.7 million or 138.4% driven by Net Investment Income, member mix, and lower than forecasted claims expenses

CalOptima Health

FY 2025-26: Management Summary (cont.)

- Enrollment
  - MTD: 877,802 members, unfavorable to budget 16,549 or 1.9% due to higher than anticipated disenrollment
  - YTD: 3,559,206 member months, unfavorable to budget 43,230 or 1.2%

FY 2025-26: Management Summary (cont.)

- Revenue
  - MTD: $391.5 million, unfavorable to budget $1.7 million or 0.4% driven by Medi-Cal (MC) Line of Business (LOB) due enrollment
  - YTD: $1,812.0 million, favorable to budget $226.7 million or 14.3% due primarily to:
    - MC LOB due to Calendar Year (CY) 2023 Hospital Directed Payments (DP), CY 2024 Quality Incentive Program (QIP) and favorable member mix
    - Offset by OneCare (OC) LOB lower than anticipated Risk Adjustment Factor (RAF)

CalOptima Health

FY 2025-26: Management Summary (cont.)

- Medical Expenses
  - MTD: $364.2 million, favorable to budget $5.8 million or 1.6% driven by:
    - $6.0 million in Professional Claims
    - $3.3 million in Medical Management
    - $0.6 million in Managed Long-Term Services and Supports (MLTSS)
    - Offset by $4.0 million unfavorable variance in all other medical expense categories

FY 2025-26: Management Summary (cont.)

- Medical Expenses
  - YTD: $1,663.7 million, unfavorable to budget $190.0 million or 12.9% due to:
    - $221.3 million in MC Other Medical Expenses primarily due to CY 2023 Hospital DP and CY 2024 QIP
    - Offset by $21.1 million in Managed Long-Term Services and Supports (MLTSS) favorable variance to budget

FY 2025-26: Management Summary (cont.)

- Administrative Expenses
  - MTD: $21.6 million, favorable to budget $4.2 million or 16.2% due to the timing of administrative expense activities
  - YTD: $85.5 million, favorable to budget $15.9 million or 15.7% due to the timing of administrative expense activities

FY 2025-26: Management Summary (cont.)

- Non-Operating Income (Loss)
  - MTD: $9.9 million, favorable to budget $1.7 million or 20.6% due primarily to $4.6 million favorable Net Investment Income, offset by Community Reinvestment contractual obligation accrual of $2.1 million and Grant Expenses of $1.0 million
  - YTD: $39.9 million, favorable to budget $7.1 million or 21.7% due primarily to $26.1 million favorable Net Investment Income, offset by Community Reinvestment contractual obligation accrual of $17.8 million and Grant Expenses of $1.5 million

FY 2025-26: Key Financial Ratios

- Medical Loss Ratio (MLR)

		Actual	Budget	Variance (%)
MTD	MLR	93.0%	94.1%	(1.1%)
	Adjusted MLR*	88.5%	89.6%	(1.1%)
YTD	MLR	91.8%	93.0%	(1.1%)
	Adjusted MLR*	86.3%	88.5%	(2.3%)

- Administrative Loss Ratio (ALR)

		Actual	Budget	Variance (%)
MTD	ALR	5.5%	6.6%	1.0%
	Adjusted ALR*	5.5%	6.6%	1.0%
YTD	ALR	4.7%	6.4%	1.7%
	Adjusted ALR*	5.4%	6.4%	1.0%

* Adjusted MLR/ALR excludes estimated Board-approved Provider Rate Increases and Directed Payments, but includes costs associated with DTS.

CalOptima Health

FY 2025-26: Key Financials Ratios (cont.)

- Balance Sheet Ratios
  - Current ratio*: 1.8
  - Board Designated Reserve level: 3.70
  - Statutory Designated Reserve level: 1.02
  - Net-position: $2.9 billion, including required TNE of $132.4 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations.

CalOptima Health

Enrollment Summary: October 2025

October 2025					July - October 2025			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category	Actual	Budget	$ Variance	% Variance
151,177	147,905	3,272	2.2%	SPD	607,644	590,146	17,498	3.0%
251,320	258,282	(6,962)	(2.7%)	TANF Child	1,015,538	1,036,864	(21,326)	(2.1%)
123,162	128,197	(5,035)	(3.9%)	TANF Adult	503,495	517,403	(13,908)	(2.7%)
3,103	2,512	591	23.5%	LTC	11,483	10,049	1,434	14.3%
321,576	330,014	(8,438)	(2.6%)	MCE	1,310,743	1,338,405	(27,662)	(2.1%)
8,717	9,087	(370)	(4.1%)	WCM	35,884	36,412	(528)	(1.5%)
859,055	**875,997**	(16,942)	(1.9%)	**Medi-Cal Total**	**3,484,787**	**3,529,279**	(44,492)	(1.3%)
18,211	**17,813**	**398**	**2.2%**	**OneCare**	**72,297**	**71,017**	**1,280**	**1.8%**
536	**541**	(5)	(0.9%)	**PACE**	**2,122**	**2,140**	(18)	(0.8%)
571	**558**	**13**	**2.3%**	**MSSP***	**2,231**	**2,232**	(1)	(0.0%)
877,802	**894,351**	(16,549)	(1.9%)	**CalOptima Health Total**	**3,559,206**	**3,602,436**	(43,230)	(1.2%)

*MSSP enrollment is included in Medi-Cal total

CalOptima Health

Consolidated Revenue & Expenses: October 2025 MTD

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	859,055	18,211	536	571		877,802
REVENUES						
Capitation Revenue	$ 349,226,097	$ 37,106,855	$ 4,949,210	$ 252,753	$ -	$ 391,534,915
Total Operating Revenue	**349,226,097**	**37,106,855**	**4,949,210**	**252,753**	**-**	**391,534,915**
MEDICAL EXPENSES						
Provider Capitation	114,340,551	14,498,375				128,838,926
Professional, Facility & Ancillary Claims	138,984,055	6,647,805	1,870,451			147,502,311
Managed Long-Term Services & Supports (MLTSS)	49,908,425		59,014	37,057		50,004,495
Prescription Drugs		12,203,578	629,466			12,833,043
Case Management & Other Medical	20,925,640	2,435,381	1,461,370	201,765		25,024,156
Total Medical Expenses	**324,158,671**	**35,785,139**	**4,020,300**	**238,822**	**-**	**364,202,932**
Medical Loss Ratio	*92.8%*	*96.4%*	*81.2%*	*94.5%*	*0.0%*	*93.0%*
GROSS MARGIN	**25,067,426**	**1,321,717**	**928,910**	**13,931**	**-**	**27,331,983**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	12,321,350	1,076,245	190,669	92,121	68,211	13,748,597
Non-Salary Operating Expenses	2,507,407	644,396	22,521	1,459	130,484	3,306,267
Depreciation & Amortization	1,041,667		886			1,042,553
Other Operating Expenses	2,963,079	118,827	11,762	10,099		3,103,767
Indirect Cost Allocation, Occupancy	(545,575)	926,722	14,716	6,351		402,215
Total Administrative Expenses	**18,287,927**	**2,766,190**	**240,556**	**110,031**	**198,694**	**21,603,398**
Administrative Loss Ratio	*5.2%*	*7.5%*	*4.9%*	*43.5%*	*0.0%*	*5.5%*
Operating Income/(Loss)	**6,779,499**	(1,444,473)	**688,355**	(96,100)	(198,694)	**5,728,585**
Investments and Other Non-Operating	(2,111,404)					9,880,003
CHANGE IN NET ASSETS	**$ 4,668,094**	$ (1,444,473)	**$ 688,355**	$ (96,100)	$ (198,694)	**$ 15,608,588**
BUDGETED CHANGE IN NET ASSETS	667,700	(2,404,464)	210,423	(121,770)	(905,270)	5,641,349
Variance to Budget - Fav/(Unfav)	$ 4,000,394	$ 959,991	$ 477,932	$ 25,670	$ 706,576	$ 9,967,239

CalOptima Health

Consolidated Revenue & Expenses: October 2025 YTD

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	3,484,787	72,297	2,122	2,231		3,559,206
REVENUES						
Capitation Revenue	$ 1,647,271,752	$ 144,413,988	$ 19,371,581	$ 988,159	$ -	$ 1,812,045,480
Total Operating Revenue	**1,647,271,752**	**144,413,988**	**19,371,581**	**988,159**	**-**	**1,812,045,480**
MEDICAL EXPENSES						
Provider Capitation	452,228,877	58,015,663				510,244,540
Professional, Facility & Ancillary Claims	570,901,120	28,612,512	8,181,050			607,694,681
Managed Long-Term Services & Supports (MLTSS)	178,418,902		180,833	142,668		178,742,402
Prescription Drugs		42,012,432	2,387,020			44,399,452
Case Management & Other Medical	306,827,716	9,300,264	5,726,200	793,167		322,647,346
Total Medical Expenses	**1,508,376,615**	**137,940,870**	**16,475,102**	**935,834**	**-**	**1,663,728,422**
Medical Loss Ratio	*91.6%*	*95.5%*	*85.0%*	*94.7%*	*0.0%*	*91.8%*
GROSS MARGIN	**138,895,137**	**6,473,118**	**2,896,478**	**52,325**	**-**	**148,317,058**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	47,007,714	4,099,216	739,558	382,319	265,315	52,494,122
Non-Salary Operating Expenses	12,309,007	1,964,033	370,199	5,852	1,322,509	15,971,600
Depreciation & Amortization	3,456,924		3,544			3,460,469
Other Operating Expenses	11,333,103	411,348	44,413	28,995		11,817,859
Indirect Cost Allocation, Occupancy	(2,080,917)	3,706,887	58,866	25,404		1,710,240
Total Administrative Expenses	**72,025,831**	**10,181,484**	**1,216,580**	**442,571**	**1,587,824**	**85,454,289**
Administrative Loss Ratio	*4.4%*	*7.1%*	*6.3%*	*44.8%*	*0.0%*	*4.7%*
Operating Income/(Loss)	**66,869,306**	(3,708,366)	**1,679,899**	(390,246)	(1,587,824)	**62,862,769**
Investments and Other Non-Operating	(17,831,408)					39,884,481
CHANGE IN NET ASSETS	**$ 49,037,898**	$ (3,708,366)	**$ 1,679,899**	$ (390,246)	$ (1,587,824)	**$ 102,747,250**
BUDGETED CHANGE IN NET ASSETS	20,607,904	(7,587,055)	1,093,970	(478,220)	(3,325,757)	43,089,762
Variance to Budget - Fav/(Unfav)	$ 28,429,994	$ 3,878,689	$ 585,929	$ 87,974	$ 1,737,933	$ 59,657,488

CalOptima Health

Balance Sheet: As of October 2025

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$324,574,430	Accounts Payable	$228,406,051
Short-term Investments	1,571,247,770	Medical Claims Liability	1,028,364,899
Capitation Receivable	646,847,667	Accrued Payroll Liabilities	22,127,423
Receivables - Other	89,486,350	Deferred Revenue	47,181,657
Prepaid Expenses	20,892,777	Other Current Liabilities	-
Total Current Assets	**2,653,048,995**	Capitation and Withholds	150,999,429
		Total Current Liabilities	**1,477,079,459**
Capital Assets		**Other Liabilities**	
Capital Assets	202,354,119	GASB 96 Subscription Liabilities	23,418,743
Less Accumulated Depreciation	(91,372,139)	Community Reinvestment	105,935,486
Capital Assets, Net of Depreciation	**110,981,980**	Capital Lease Payable	229,567
		Postemployment Health Care Plan	17,336,844
Other Assets		Net Pension Liabilities	5,840,992
Restricted Deposits	300,000	**Total Other Liabilities**	**152,761,632**
Board Designated Reserves	1,609,893,771		
Statutory Designated Reserves	134,630,744	**TOTAL LIABILITIES**	**1,629,841,091**
Total Other Assets	**1,744,824,515**		
TOTAL ASSETS	**4,508,855,489**	**Deferred Inflows**	**4,309,519**
Deferred Outflows	**28,626,072**	**Net Position**	
		Required TNE	132,360,378
		Funds in Excess of TNE	2,770,970,573
		TOTAL NET POSITION	**2,903,330,951**
TOTAL ASSETS & DEFERRED OUTFLOWS	**4,537,481,561**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**4,537,481,561**

CalOptima Health

Board Designated Reserve and TNE Analysis: As of October 2025

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	804,884,085				
MetLife Tier One	805,009,685				
Board Designated Reserves	1,609,893,771	1,087,894,962	1,740,631,940	521,998,808	(130,738,169)
Current Reserve Level (X months of average monthly revenue) [1]	*3.70*	*2.50*	*4.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	67,431,417				
MetLife Tier Two	67,199,327				
Statutory Designated Reserves	134,630,744	132,360,378	145,596,415	2,270,366	(10,965,672)
Current Reserve Level (X min. TNE) [1]	*1.02*	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

CalOptima Health

Spending Plan: As of October 2025

Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
Total Net Position @ 10/31/2025	**$2,903.3**			**100.0%**
Resources Assigned				
Board Designated Reserve[1]	**$1,609.9**			**55.4%**
Statutory Designated Reserve[1]	**$134.6**			**4.6%**
Capital Assets, net of Depreciation	**$111.0**			**3.8%**
Resources Allocated[3]				
Homeless Health Initiative[2]	$17.7	$65.8	$48.2	0.6%
Housing and Homelessness Incentive Program[2]	24.8	87.4	62.6	0.9%
Intergovernmental Transfers (IGT)[4]	39.3	52.1	12.8	1.4%
Digital Transformation and Workplace Modernization[3]	23.9	100.0	76.1	0.8%
CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
CalFresh and Redetermination Outreach Strategy	1.8	6.0	4.2	0.1%
Coalition of Orange County Community Health Centers Grant	25.7	50.0	24.3	0.9%
Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
General Awareness Campaign	0.4	4.7	4.3	0.0%
Member Health Needs Assessment	0.5	1.3	0.7	0.0%
Five-Year Hospital Quality Program Beginning MY 2023	116.6	153.5	36.9	4.0%
Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.3%
In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
National Alliance for Mental Illness Orange County Peer Support Program Grant	3.0	5.0	2.0	0.1%
Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
Wellness & Prevention Program Grant	1.3	2.7	1.4	0.0%
CalOptima Health Provider Workforce Development Fund Grant	43.3	50.0	6.7	1.5%
Distribution Event - Naloxone Grant	2.2	15.0	12.8	0.1%
Garden Grove Bldg. Improvement	9.7	10.5	0.8	0.3%
CalOptima Health Community Reinvestment Program	19.0	19.0	0.0	0.7%
Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
Outreach Strategy for newly eligible Adult Expansion members	1.1	6.8	5.8	0.0%
Quality Initiatives from unearned Pay for Value Program	18.1	23.3	5.2	0.6%
Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.0	1.0	1.0	0.0%
Medi-Cal Provider Rate Increases	245.6	526.2	280.6	8.5%
Homeless Prevention and Stabilization Pilot Program	0.2	0.3	0.1	0.0%
OneCare Member Engagement and Education	0.2	0.3	0.1	0.0%
Medi-Cal Eligibility Outreach Strategy	19.8	19.8	0.0	0.7%
Subtotal:	**$627.0**	**$1,236.4**	**$609.5**	**21.6%**
Resources Available for New Initiatives				
Unallocated/Unassigned[1]	**$420.9**			**14.5%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 183 days of CalOptima Health's current operations.

[2] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.

[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

[4] On June 5, 2025, the Board of Directors approved the close out of Board-approved initiatives and transfer of remaining funds back to unallocated reserves.

CalOptima Health

Homeless Health Initiative and Allocated Funds: As of October 2025

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
HHI - IGT'S	64,033,726	64,033,726	48,151,228	15,882,498	-
HHI - Existing Reserves	1,800,000	1,800,000	-	1,800,000	-
HHIP	40,100,000	40,100,000	-	40,100,000	-
Total	**105,933,726**	**105,933,726**	**48,151,228**	**57,782,498**	**-**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-	IGT's
Recuperative Care	6,194,190	6,194,190	-	IGT's
Medical Respite	250,000	250,000	-	IGT's
Day Habilitation (County for HomeKey)	2,500,000	-	2,500,000	IGT's
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-	IGT's
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-	IGT's
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522	IGT's
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	925,540	37,721	IGT's
FQHC (Community Health Center) Expansion	21,902	21,902	-	IGT's
HCAP and CalOptima Health Days	9,888,914	4,705,022	5,183,892	IGT's
Vaccination Intervention and Member Incentive Strategy[2]	54,649	54,649	-	IGT's
Street Medicine[1]	14,279,077	9,085,700	5,193,377	IGT's & Existing Reserves
Outreach and Engagement	7,000,000	2,276,015	4,723,985	IGT's
Housing and Homelessness Incentive Program (HHIP)[3]	40,100,000	-	40,100,000	IGT's & Existing Reserves
Subtotal of Approved Initiatives	**105,933,726**	**48,151,228**	**57,782,497**	
Transfer of funds to HHIP[3]	(40,100,000)	-	(40,100,000)	
Program Total	**65,833,726**	**48,151,228**	**17,682,497**	

[1]On August 7, 2025, CalOptima Health's Board of Directors approved $9.3 million to expand the Street Medicine Program - $3.2 million remaining from Street Medicine Initiative (from the Homeless Health Initiatives Reserve), $1.8 million from Existing Reserves, and $4.3 million from Intergovernmental Transfer balance resulting from a June 5, 2025, Board of of Director action, to fund 2-year grant agreements to Healthcare in Action (Anaheim), Celebrating Life Community Health Center (Costa Mesa), and AltaMed (Santa Ana).

[2]On June 5, 2025 the Board of Directors approved the close out of the Vaccination Intervention and Member Incentive Strategy program and transfer of the remaining funds of $68,699 to unallocated reserves for new initiatives.

[3]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP.

CalOptima Health

Housing and Homelessness Incentive Program: As of October 2025

Summary by Funding Source:	Total Funds[1]	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	72,931,189	32,995,535	39,935,654	$18,000,195
Existing Reserves & HHI Transfer	87,384,530	87,384,530	62,633,259	24,751,271	-
Total	**160,315,719**	**160,315,719**	**95,628,794**	**64,686,926**	**18,000,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	882,700	517,300	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,871,311	3,721,311	1,150,001	HHI & DHCS
Infrastructure Projects	5,832,314	5,698,977	133,337	HHI
Capital Projects	123,497,564	74,146,735	49,350,829	HHI, DHCS & Existing Reserves
System Change Projects	21,814,530	8,323,680	13,490,850	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	**$160,315,719[1]**	**$95,628,794**	**64,686,926**	

[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

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UNAUDITED FINANCIAL STATEMENTS

October 31, 2025

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CalOptima Health - Consolidated
Financial Highlights
For the Four Months Ending October 31, 2025

October 2025					July - October 2025			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
877,802	894,351	(16,549)	(1.9%)	Member Months	3,559,206	3,602,436	(43,230)	(1.2%)
391,534,915	393,262,363	(1,727,448)	(0.4%)	Revenues	1,812,045,480	1,585,363,351	226,682,129	14.3%
364,202,932	370,044,385	5,841,453	1.6%	Medical Expenses	1,663,728,422	1,473,709,557	(190,018,865)	(12.9%)
21,603,398	25,771,359	4,167,961	16.2%	Administrative Expenses	85,454,289	101,342,952	15,888,662	15.7%
5,728,585	(2,553,381)	**8,281,966**	**324.4%**	**Operating Margin**	**62,862,769**	**10,310,842**	**52,551,927**	**509.7%**
				Non-Operating Income (Loss)				
12,922,471	8,333,340	4,589,131	55.1%	Net Investment Income/Expense	59,447,383	33,333,360	26,114,023	78.3%
(1,002,221)	-	(1,002,221)	(100.0%)	Grant Expense	(1,459,767)	-	(1,459,767)	(100.0%)
(2,112,864)	-	(2,112,864)	(100.0%)	Community Reinvestment	(17,837,375)	-	(17,837,375)	(100.0%)
72,617	(138,610)	211,227	152.4%	Other Income/Expense	(265,760)	(554,440)	288,680	52.1%
9,880,003	**8,194,730**	**1,685,273**	**20.6%**	**Total Non-Operating Income (Loss)**	**39,884,481**	**32,778,920**	**7,105,561**	**21.7%**
15,608,588	**5,641,349**	**9,967,239**	**176.7%**	**Change in Net Assets**	**102,747,250**	**43,089,762**	**59,657,488**	**138.4%**
93.0%	*94.1%*	(1.1%)		*Medical Loss Ratio*	*91.8%*	*93.0%*	(1.1%)	
5.5%	*6.6%*	*1.0%*		*Administrative Loss Ratio*	*4.7%*	*6.4%*	*1.7%*	
1.5%	(0.6%)	*2.1%*		*Operating Margin Ratio*	*3.5%*	*0.7%*	*2.8%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
88.5%	*89.6%*	(1.1%)		**Adjusted MLR*	*86.3%*	*88.5%*	(2.3%)	
5.5%	*6.6%*	*1.0%*		**Adjusted ALR*	*5.4%*	*6.4%*	*1.0%*	

*Adjusted MLR /ALR excludes estimated Board-approved Provider Rate increases and Directed Payments, but includes costs associated with CalOptima Health's Digital Transformation Strategy (DTS) budget.

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CalOptima Health - Consolidated
Full Time Equivalent (FTE) Data
For the Four Months Ending October 31, 2025

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1,319	1,408	89
OneCare	165	182	17
PACE	112	119	7
CCA	3	17	14
MSSP	21	24	3
Total	1,622	1,750	128

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	5,298	5,624	326
OneCare	666	725	59
PACE	447	476	29
CCA	11	52	41
MSSP	88	95	7
Total	6,509	6,972	462

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	651	622	(29)
OneCare	110	98	(12)
PACE	5	5	(0)
CCA	0	0	0
MSSP	27	23	(4)
Consolidated	541	511	(30)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	658	628	(30)
OneCare	109	98	(11)
PACE	5	4	(1)
CCA	0	0	0
MSSP	25	23	(2)
Consolidated	547	517	(30)

Open FTE			
	Total	Medical	Admin
Medi-Cal	93	32	61
OneCare	7	7	0
PACE	17	1	16
CCA	0	0	0
MSSP	0	0	0
Total	117	40	77

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending October 31, 2025

MEMBER MONTHS		877,802		894,351		(16,549)
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$349,226,097	$406.52	$351,148,919	$400.86	($1,922,822)	$5.66
OneCare	37,106,855	2,037.61	37,025,387	2,078.56	81,468	(40.95)
PACE	4,949,210	9,233.60	4,839,003	8,944.55	110,207	289.05
MSSP	252,753	442.65	249,054	446.33	3,699	(3.68)
Total Operating Revenue	391,534,915	446.04	393,262,363	439.72	(1,727,448)	6.32
MEDICAL EXPENSES						
Medi-Cal	324,158,671	377.34	329,275,734	375.89	5,117,063	(1.45)
OneCare	35,785,139	1,965.03	36,192,477	2,031.80	407,338	66.77
PACE	4,020,300	7,500.56	4,304,098	7,955.82	283,798	455.26
MSSP	238,822	418.25	227,092	406.97	(11,730)	(11.28)
Covered CA		-	44,984	80.62	44,984	80.62
Total Medical Expenses	364,202,932	414.90	370,044,385	413.76	5,841,453	(1.14)
GROSS MARGIN	27,331,983	31.14	23,217,978	25.96	4,114,005	5.18
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	13,748,597	15.66	14,485,249	16.20	736,653	0.54
Professional Fees	861,459	0.98	1,941,119	2.17	1,079,660	1.19
Purchased Services	1,915,693	2.18	2,807,953	3.14	892,260	0.96
Printing & Postage	529,116	0.60	620,975	0.69	91,859	0.09
Depreciation & Amortization	1,042,553	1.19	949,334	1.06	(93,219)	(0.13)
Other Expenses	3,103,767	3.54	4,484,861	5.01	1,381,094	1.47
Indirect Cost Allocation, Occupancy	402,215	0.46	481,868	0.54	79,653	0.08
Total Administrative Expenses	21,603,398	24.61	25,771,359	28.82	4,167,961	4.21
NET INCOME (LOSS) FROM OPERATIONS	5,728,585	6.53	(2,553,381)	(2.86)	8,281,966	9.39
INVESTMENT INCOME						
Interest Income	13,772,599	15.69	8,333,340	9.32	5,439,259	6.37
Realized Gain/(Loss) on Investments	410,829	0.47	-	-	410,829	0.47
Unrealized Gain/(Loss) on Investments	(1,260,957)	(1.44)	-	-	(1,260,957)	(1.44)
Total Investment Income	12,922,471	14.72	8,333,340	9.32	4,589,131	5.40
GRANT EXPENSE	(1,002,221)	(1.14)	-	-	(1,002,221)	(1.14)
COMMUNITY REINVESTMENT	(2,112,864)	(2.41)	-	-	(2,112,864)	(2.41)
OTHER INCOME/EXPENSE	72,617	0.08	(138,610)	(0.15)	211,227	0.23
CHANGE IN NET ASSETS	**15,608,588**	**17.78**	**5,641,349**	**6.31**	**9,967,239**	**11.47**
MEDICAL LOSS RATIO	**93.0%**		**94.1%**		(1.1%)	
ADMINISTRATIVE LOSS RATIO	**5.5%**		**6.6%**		**1.0%**	

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CalOptima Health- Consolidated - Year to Date
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2025

MEMBER MONTHS		3,559,206		3,602,436		(43,230)
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$1,647,271,752	$472.70	$1,416,403,375	$401.33	$230,868,377	$71.37
OneCare	144,413,988	1,997.51	148,772,901	2,094.89	(4,358,913)	(97.38)
PACE	19,371,581	9,128.93	19,190,859	8,967.69	180,722	161.24
MSSP	988,159	442.92	996,216	446.33	(8,057)	(3.41)
Total Operating Revenue	1,812,045,480	509.12	1,585,363,351	440.08	226,682,129	69.04
MEDICAL EXPENSES						
Medi-Cal	1,508,376,615	432.85	1,312,232,803	371.81	(196,143,812)	(61.04)
OneCare	137,940,870	1,907.98	143,574,326	2,021.69	5,633,456	113.71
PACE	16,475,102	7,763.95	16,814,124	7,857.07	339,022	93.12
MSSP	935,834	419.47	908,368	406.97	(27,466)	(12.50)
Covered CA		0.00	179,936	80.62	179,936	80.62
Total Medical Expenses	1,663,728,422	467.44	1,473,709,557	409.09	(190,018,865)	(58.35)
GROSS MARGIN	148,317,058	41.68	111,653,794	30.99	36,663,264	10.69
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	52,494,122	14.75	56,408,513	15.66	3,914,392	0.91
Professional Fees	5,372,615	1.51	7,684,458	2.13	2,311,843	0.62
Purchased Services	8,486,388	2.38	11,057,175	3.07	2,570,787	0.69
Printing & Postage	2,112,597	0.59	2,497,900	0.69	385,303	0.10
Depreciation & Amortization	3,460,469	0.97	3,797,336	1.05	336,867	0.08
Other Expenses	11,817,859	3.32	17,970,097	4.99	6,152,238	1.67
Indirect Cost Allocation, Occupancy	1,710,240	0.48	1,927,472	0.54	217,232	0.06
Total Administrative Expenses	85,454,289	24.01	101,342,952	28.13	15,888,662	4.12
NET INCOME (LOSS) FROM OPERATIONS	62,862,769	17.66	10,310,842	2.86	52,551,927	14.80
INVESTMENT INCOME						
Interest Income	55,506,223	15.60	33,333,360	9.25	22,172,863	6.35
Realized Gain/(Loss) on Investments	2,400,076	0.67	-	0.00	2,400,076	0.67
Unrealized Gain/(Loss) on Investments	1,541,084	0.43	-	0.00	1,541,084	0.43
Total Investment Income	59,447,383	16.70	33,333,360	9.25	26,114,023	7.45
GRANT EXPENSE	(1,459,767)	(0.41)	-	0.00	(1,459,767)	(0.41)
COMMUNITY REINVESTMENT	(17,837,375)	(5.01)	-	0.00	(17,837,375)	(5.01)
OTHER INCOME/EXPENSE	(265,760)	(0.07)	(554,440)	(0.15)	288,680	0.08
CHANGE IN NET ASSETS	**102,747,250**	**28.87**	**43,089,762**	**11.96**	**59,657,488**	**16.91**
MEDICAL LOSS RATIO	**91.8%**		**93.0%**		(1.1%)	
ADMINISTRATIVE LOSS RATIO	**4.7%**		**6.4%**		**1.7%**	

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CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending October 31, 2025

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	859,055	18,211	536	571	-	877,802
REVENUES						
Capitation Revenue	$ 349,226,097	$ 37,106,855	$ 4,949,210	$ 252,753	$ -	$ 391,534,915
Total Operating Revenue	**349,226,097**	**37,106,855**	**4,949,210**	**252,753**	**-**	**391,534,915**
MEDICAL EXPENSES						
Provider Capitation	114,340,551	14,498,375				128,838,926
Professional, Facilty and Ancillary Claims	138,984,055	6,647,805	1,870,451			147,502,311
Managed Long-Term Services & Supports (MLTSS)	49,908,425		59,014	37,057		50,004,495
Prescription Drugs		12,203,578	629,466			12,833,043
Case Management & Other Medical	20,925,640	2,435,381	1,461,370	201,765		25,024,156
Total Medical Expenses	**324,158,671**	**35,785,139**	**4,020,300**	**238,822**	**-**	**364,202,932**
Medical Loss Ratio	*92.8%*	*96.4%*	*81.2%*	*94.5%*	*0.0%*	*93.0%*
GROSS MARGIN	**25,067,426**	**1,321,717**	**928,910**	**13,931**	**-**	**27,331,983**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	12,321,350	1,076,245	190,669	92,121	68,211	13,748,597
Non-Salary Operating Expenses	2,507,407	644,396	22,521	1,459	130,484	3,306,267
Depreciation & Amortization	1,041,667		886			1,042,553
Other Operating Expenses	2,963,079	118,827	11,762	10,099		3,103,767
Indirect Cost Allocation, Occupancy	(545,575)	926,722	14,716	6,351		402,215
Total Administrative Expenses	**18,287,927**	**2,766,190**	**240,556**	**110,031**	**198,694**	**21,603,398**
Administrative Loss Ratio	*5.2%*	*7.5%*	*4.9%*	*43.5%*	*0.0%*	*5.5%*
Operating Income/(Loss)	**6,779,499**	(1,444,473)	**688,355**	(96,100)	(198,694)	**5,728,585**
Investments and Other Non-Operating	(2,111,404)					9,880,003
CHANGE IN NET ASSETS	**$ 4,668,094**	$ (1,444,473)	**$ 688,355**	$ (96,100)	$ (198,694)	**$ 15,608,588**
BUDGETED CHANGE IN NET ASSETS	667,700	(2,404,464)	210,423	(121,770)	(905,270)	5,641,349
Variance to Budget - Fav/(Unfav)	$ 4,000,394	$ 959,991	$ 477,932	$ 25,670	$ 706,576	$ 9,967,239

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CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Four Months Ending October 31, 2025

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	3,484,787	72,297	2,122	2,231	-	3,559,206
REVENUES						
Capitation Revenue	$ 1,647,271,752	$ 144,413,988	$ 19,371,581	$ 988,159	$ -	$ 1,812,045,480
Total Operating Revenue	**1,647,271,752**	**144,413,988**	**19,371,581**	**988,159**	**-**	**1,812,045,480**
MEDICAL EXPENSES						
Provider Capitation	452,228,877	58,015,663				510,244,540
Professional, Facilty and Ancillary Claims	570,901,120	28,612,512	8,181,050			607,694,681
Managed Long-Term Services & Supports (MLTSS)	178,418,902		180,833	142,668		178,742,402
Prescription Drugs		42,012,432	2,387,020			44,399,452
Case Management & Other Medical	306,827,716	9,300,264	5,726,200	793,167		322,647,346
Total Medical Expenses	**1,508,376,615**	**137,940,870**	**16,475,102**	**935,834**	**-**	**1,663,728,422**
Medical Loss Ratio	*91.6%*	*95.5%*	*85.0%*	*94.7%*	*0.0%*	*91.8%*
GROSS MARGIN	**138,895,137**	**6,473,118**	**2,896,478**	**52,325**	**-**	**148,317,058**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	47,007,714	4,099,216	739,558	382,319	265,315	52,494,122
Non-Salary Operating Expenses	12,309,007	1,964,033	370,199	5,852	1,322,509	15,971,600
Depreciation & Amortization	3,456,924		3,544			3,460,469
Other Operating Expenses	11,333,103	411,348	44,413	28,995		11,817,859
Indirect Cost Allocation, Occupancy	(2,080,917)	3,706,887	58,866	25,404		1,710,240
Total Administrative Expenses	**72,025,831**	**10,181,484**	**1,216,580**	**442,571**	**1,587,824**	**85,454,289**
Administrative Loss Ratio	*4.4%*	*7.1%*	*6.3%*	*44.8%*	*0.0%*	*4.7%*
Operating Income/(Loss)	**66,869,306**	(3,708,366)	**1,679,899**	(390,246)	(1,587,824)	**62,862,769**
Investments and Other Non-Operating	(17,831,408)					39,884,481
CHANGE IN NET ASSETS	**$ 49,037,898**	$ (3,708,366)	**$ 1,679,899**	$ (390,246)	$ (1,587,824)	**$ 102,747,250**
BUDGETED CHANGE IN NET ASSETS	20,607,904	(7,587,055)	1,093,970	(478,220)	(3,325,757)	43,089,762
Variance to Budget - Fav/(Unfav)	$ 28,429,994	$ 3,878,689	$ 585,929	$ 87,974	$ 1,737,933	$ 59,657,488

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CalOptima Health

Highlights – Consolidated, for Four Months Ending October 31, 2025

MONTH TO DATE RESULTS:

- Change in Net Assets is $15.6 million, favorable to budget $10.0 million
- Operating surplus is $5.7 million, with a surplus in non-operating income of $9.9 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $102.7 million, favorable to budget $59.7 million
- Operating surplus is $62.9 million, with a surplus in non-operating income of $39.9 million

Change in Net Assets by Line of Business (LOB) ($ millions):

October 2025				July - October 2025		
Actual	**Budget**	**Variance**	**Operating Income (Loss)**	**Actual**	**Budget**	**Variance**
6.8	0.7	6.1	Medi-Cal	66.9	20.6	46.3
(1.4)	(2.4)	1.0	OneCare	(3.7)	(7.6)	3.9
0.7	0.2	0.5	PACE	1.7	1.1	0.6
(0.1)	(0.1)	0.0	MSSP	(0.4)	(0.5)	0.1
(0.2)	(0.9)	0.7	Covered CA	(1.6)	(3.3)	1.7
5.7	**(2.6)**	**8.3**	**Total Operating Income (Loss)**	**62.9**	**10.3**	**52.6**
			Non-Operating Income (Loss)			
12.9	8.3	4.6	Net Investment Income/Expense	59.4	33.3	26.1
(3.0)	(0.1)	(2.9)	Other Income/Expense	0.0	(19.6)	(0.6)
9.9	**8.2**	**1.7**	**Total Non-Operating Income/(Loss)**	**39.9**	**32.8**	**7.1**
15.6	**5.6**	**10.0**	**TOTAL**	**102.7**	**43.1**	**59.7**

CalOptima Health - Consolidated
Enrollment Summary
For the Four Months Ending October 31, 2025

October 2025					July - October 2025			
Actual	**Budget**	**$ Variance**	**%Variance**	**Enrollment (by Aid Category)**	**Actual**	**Budget**	**$ Variance**	**%Variance**
151,177	147,905	3,272	2.2%	SPD	607,644	590,146	17,498	3.0%
251,320	258,282	(6,962)	(2.7%)	TANF Child	1,015,538	1,036,864	(21,326)	(2.1%)
123,162	128,197	(5,035)	(3.9%)	TANF Adult	503,495	517,403	(13,908)	(2.7%)
3,103	2,512	591	23.5%	LTC	11,483	10,049	1,434	14.3%
321,576	330,014	(8,438)	(2.6%)	MCE	1,310,743	1,338,405	(27,662)	(2.1%)
8,717	9,087	(370)	(4.1%)	WCM	35,884	36,412	(528)	(1.5%)
859,055	**875,997**	(16,942)	(1.9%)	**Medi-Cal Total**	**3,484,787**	**3,529,279**	(44,492)	(1.3%)
18,211	**17,813**	**398**	**2.2%**	**OneCare**	**72,297**	**71,017**	**1,280**	**1.8%**
536	**541**	(5)	(0.9%)	**PACE**	**2,122**	**2,140**	(18)	(0.8%)
571	**558**	**13**	**2.3%**	**MSSP**	**2,231**	**2,232**	(1)	(0.0%)
877,802	**894,351**	(16,549)	(1.9%)	**CalOptima Health Total**	**3,559,206**	**3,602,436**	(43,230)	(1.2%)
				Enrollment (by Network)				
345,208	346,290	(1,082)	(0.3%)	HMO	1,380,951	1,400,352	(19,401)	(1.4%)
161,436	163,161	(1,725)	(1.1%)	PHC	655,248	658,492	(3,244)	(0.5%)
64,474	67,145	(2,671)	(4.0%)	Shared Risk Group	264,363	270,070	(5,707)	(2.1%)
287,937	299,401	(11,464)	(3.8%)	Fee for Service	1,184,225	1,200,365	(16,140)	(1.3%)
859,055	**875,997**	(16,942)	(1.9%)	**Medi-Cal Total**	**3,484,787**	**3,529,279**	(44,492)	(1.3%)
18,211	**17,813**	**398**	**2.2%**	**OneCare**	**72,297**	**71,017**	**1,280**	**1.8%**
536	**541**	(5)	(0.9%)	**PACE**	**2,122**	**2,140**	(18)	(0.8%)
571	**558**	**13**	**2.3%**	**MSSP**	**2,231**	**2,232**	(1)	(0.0%)
877,802	**894,351**	(16,549)	(1.9%)	**CalOptima Health Total**	**3,559,206**	**3,602,436**	(43,230)	(1.2%)

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2026

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD Actual	YTD Budget	Variance
HMOs															
SPD	20,739	20,738	20,896	20,798									83,171	80,206	2,965
TANF Child	73,203	72,978	72,855	72,899									291,935	306,661	(14,726)
TANF Adult	67,587	67,579	68,311	68,508									271,985	271,917	68
LTC	3	12	(1)										14	4	10
MCE	182,912	181,318	182,080	181,632									727,942	735,845	(7,903)
WCM	1,508	1,526	1,499	1,371									5,904	5,720	184
Total	**345,952**	**344,151**	**345,640**	**345,208**									**1,380,951**	**1,400,353**	(19,402)
PHCs															
SPD	4,775	4,791	4,754	4,517									18,837	18,422	415
TANF Child	129,804	128,525	127,408	126,859									512,596	512,954	(358)
TANF Adult	3,936	3,870	3,761	3,668									15,235	15,581	(346)
LTC													0		0
MCE	21,807	21,373	20,988	20,479									84,647	87,251	(2,604)
WCM	6,119	5,909	5,992	5,913									23,933	24,284	(351)
Total	**166,441**	**164,468**	**162,903**	**161,436**									**655,248**	**658,492**	(3,244)
Shared Risk Groups															
SPD	3,418	3,327	3,355	3,268									13,368	12,619	749
TANF Child	18,444	18,179	17,845	17,764									72,232	71,774	458
TANF Adult	11,382	11,126	10,872	10,652									44,032	45,566	(1,534)
LTC		1											1		1
MCE	34,473	33,658	33,030	32,525									133,686	138,606	(4,920)
WCM	226	252	301	265									1,044	1,505	(461)
Total	**67,943**	**66,543**	**65,403**	**64,474**									**264,363**	**270,070**	(5,707)
Fee for Service (Dual)															
SPD	107,827	107,645	108,097	108,113									431,682	413,914	17,768
TANF Child		1											1		1
TANF Adult	876	859	867	846									3,448	4,489	(1,041)
LTC	2,311	2,446	2,667	2,763									10,187	8,906	1,281
MCE	3,187	3,126	3,065	3,171									12,549	20,116	(7,567)
WCM	15	26	15	13									69	57	12
Total	**114,216**	**114,103**	**114,711**	**114,906**									**457,936**	**447,482**	**10,454**
Fee for Service (Non-Dual - Total)															
SPD	15,643	15,501	14,961	14,481									60,586	64,985	(4,399)
TANF Child	35,975	34,671	34,330	33,798									138,774	145,476	(6,702)
TANF Adult	44,785	43,246	41,276	39,488									168,795	179,850	(11,055)
LTC	286	305	350	340									1,281	1,139	142
MCE	93,242	89,170	85,738	83,769									351,919	356,587	(4,668)
WCM	1,296	1,252	1,231	1,155									4,934	4,846	88
Total	**191,227**	**184,145**	**177,886**	**173,031**									**726,289**	**752,883**	(26,594)
Grand Totals															
SPD	152,402	152,002	152,063	151,177									607,644	590,146	17,498
TANF Child	257,426	254,354	252,438	251,320									1,015,538	1,036,865	(21,327)
TANF Adult	128,566	126,680	125,087	123,162									503,495	517,403	(13,908)
LTC	2,600	2,764	3,016	3,103									11,483	10,049	1,434
MCE	335,621	328,645	324,901	321,576									1,310,743	1,338,405	(27,662)
WCM	9,164	8,965	9,038	8,717									35,884	36,412	(528)
Total MediCal MM	**885,779**	**873,410**	**866,543**	**859,055**									**3,484,787**	**3,529,279**	(44,492)
OneCare	**17,971**	**17,873**	**18,242**	**18,211**									**72,297**	**71,017**	**1,280**
PACE	**528**	**529**	**529**	**536**									**2,122**	**2,140**	(18)
MSSP	**553**	**551**	**556**	**571**									**2,231**	**2,232**	(1)
Covered CA	**0**	**0**	**0**	**0**									**0**	**0**	**0**
Grand Total	**904,278**	**891,812**	**885,314**	**877,802**									**3,559,206**	**3,602,436**	(43,230)

Note:* Total membership does not include MSSP

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ENROLLMENT– OCTOBER MONTH:

Overall, October enrollment was 877,802

- Unfavorable to budget 16,549 or 1.9%
- Decreased 7,512 or 0.8% from Prior Month (PM) (September 2025)
- Decreased 32,261 or 3.5% from Prior Year (PY) (October 2024)

Medi-Cal enrollment was 859,055

- Unfavorable to budget 16,942 or 1.9% due to higher than anticipated disenrollment
- Temporary Assistance for Needy Families (TANF) unfavorable to budget 11,997
- Medi-Cal Expansion (MCE) unfavorable to budget 8,438
- Whole Child Model (WCM) unfavorable to budget 370
- Seniors and Persons with Disabilities (SPD) favorable to budget 3,272
- Long-Term Care (LTC) favorable to budget 591
- Decreased 7,488 or 0.9% from PM

OneCare enrollment was 18,211

- Favorable to budget 398 or 2.2%
- Decreased 31 or 0.2% from PM

PACE enrollment was 536

- Unfavorable to budget 5 or 0.9%
- Increased 7 or 1.3% from PM

MSSP enrollment was 571

- Favorable to budget 13 or 2.3%
- Increased 15 or 2.7% from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
859,055	**875,997**	(16,942)	(1.9%)	**Member Months**	**3,484,787**	**3,529,279**	(44,492)	(1.3%)
				Revenues				
349,226,097	351,148,919	(1,922,822)	(0.5%)	Medi-Cal Capitation Revenue	1,647,271,752	1,416,403,375	230,868,377	16.3%
349,226,097	**351,148,919**	(1,922,822)	(0.5%)	**Total Operating Revenue**	**1,647,271,752**	**1,416,403,375**	**230,868,377**	**16.3%**
				Medical Expenses				
114,340,551	112,511,964	(1,828,587)	(1.6%)	Provider Capitation	452,228,877	454,016,740	1,787,863	0.4%
69,167,667	67,670,648	(1,497,019)	(2.2%)	Facilities Claims	282,893,968	268,451,570	(14,442,398)	(5.4%)
69,816,388	76,050,735	6,234,347	8.2%	Professional Claims	288,007,152	300,332,936	12,325,784	4.1%
49,908,425	50,485,645	577,220	1.1%	MLTSS	178,418,902	199,538,033	21,119,131	10.6%
10,480,440	9,489,660	(990,780)	(10.4%)	Incentive Payments	43,626,944	38,202,984	(5,423,960)	(14.2%)
8,634,833	11,233,762	2,598,929	23.1%	Medical Management	34,482,111	44,296,244	9,814,133	22.2%
1,810,367	1,833,320	22,953	1.3%	Other Medical Expenses	228,718,661	7,394,296	(221,324,365)	(2,993.2%)
324,158,671	**329,275,734**	**5,117,063**	**1.6%**	**Total Medical Expenses**	**1,508,376,615**	**1,312,232,803**	(196,143,812)	(14.9%)
25,067,426	**21,873,185**	**3,194,241**	**14.6%**	**Gross Margin**	**138,895,137**	**104,170,572**	**34,724,565**	**33.3%**
				Administrative Expenses				
12,321,350	12,594,937	273,587	2.2%	Salaries, Wages & Employee Benefits	47,007,714	49,280,477	2,272,763	4.6%
422,106	1,389,629	967,523	69.6%	Professional Fees	3,560,393	5,478,706	1,918,313	35.0%
1,778,773	2,226,968	448,195	20.1%	Purchased Services	7,134,230	8,796,871	1,662,641	18.9%
306,528	478,060	171,532	35.9%	Printing & Postage	1,614,385	1,926,240	311,855	16.2%
1,041,667	947,712	(93,955)	(9.9%)	Depreciation & Amortization	3,456,924	3,790,848	333,924	8.8%
2,963,079	4,309,555	1,346,477	31.2%	Other Operating Expenses	11,333,103	17,255,029	5,921,926	34.3%
(545,575)	(741,376)	(195,801)	(26.4%)	Indirect Cost Allocation, Occupancy	(2,080,917)	(2,965,504)	(884,587)	(29.8%)
18,287,927	**21,205,485**	**2,917,557**	**13.8%**	**Total Administrative Expenses**	**72,025,831**	**83,562,668**	**11,536,837**	**13.8%**
				Non-Operating Income (Loss)				
(2,112,864)	-	(2,112,864)	(100.0%)	Community Reinvestment	(17,837,375)	-	(17,837,375)	(100.0%)
1,460	-	1,460	100.0%	Other Income/Expense	5,967	-	5,967	100.0%
(2,111,404)	-	(2,111,404)	(100.0%)	**Total Non-Operating Income (Loss)**	(17,831,408)	-	(17,831,408)	(100.0%)
4,668,094	**667,700**	**4,000,394**	**599.1%**	**Change in Net Assets**	**49,037,898**	**20,607,904**	**28,429,994**	**138.0%**
92.8%	***93.8%***	(0.9%)		***Medical Loss Ratio***	***91.6%***	***92.6%***	(1.1%)	
5.2%	***6.0%***	***0.8%***		***Admin Loss Ratio***	***4.4%***	***5.9%***	***1.5%***	

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MEDI-CAL INCOME STATEMENT– OCTOBER MONTH:

REVENUES are $349.2 million, unfavorable to budget $1.9 million:

- Unfavorable volume variance of $6.8 million
- Favorable price related variance of $4.9 million
  - $1.8 million due to updated estimates in Calendar Year (CY) 2024 Quality Incentive Program (QIP)
  - $3.1 million due to favorable member mix offset by Proposition 56, Enhanced Care Management (ECM) and Unsatisfactory Immigration Status (UIS) risk corridors

MEDICAL EXPENSES are $324.2 million, favorable to budget $5.1 million:

- Favorable volume variance of $6.4 million
- Unfavorable price related variance of $1.3 million:
  - Provider Capitation expense unfavorable variance of $4.0 million
  - Facilities Claims expense unfavorable variance of $2.8 million
  - Incentive Payments expense unfavorable variance of $1.2 million
  - Managed Long-Term Services and Supports (MLTSS) unfavorable variance of $0.4 million
  - Offset by:
    - Professional claims expense favorable variance of $4.8 million
    - Medical Management expense favorable variance of $2.4 million

ADMINISTRATIVE EXPENSES are $18.3 million, favorable to budget $2.9 million:

- Non-Salary expense favorable to budget $2.6 million
- Salaries, Wages & Employee Benefits expense favorable to budget $0.3 million

CHANGE IN NET ASSETS is $4.7 million, favorable to budget $4.0 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
18,211	**17,813**	**398**	**2.2%**	**Member Months**	**72,297**	**71,017**	**1,280**	**1.8%**
				Revenues				
25,611,580	27,463,774	(1,852,194)	(6.7%)	Medicare Part C Revenue	102,007,421	110,552,259	(8,544,838)	(7.7%)
11,495,275	9,561,613	1,933,662	20.2%	Medicare Part D Revenue	42,406,568	38,220,642	4,185,926	11.0%
37,106,855	**37,025,387**	**81,468**	**0.2%**	**Total Operating Revenue**	**144,413,988**	**148,772,901**	(4,358,913)	(2.9%)
				Medical Expenses				
14,498,375	16,002,280	1,503,905	9.4%	Provider Capitation	58,015,663	64,404,514	6,388,851	9.9%
4,364,205	5,233,978	869,773	16.6%	Facilities Claims	19,314,073	20,341,556	1,027,483	5.1%
2,283,601	2,026,931	(256,670)	(12.7%)	Professional Claims	9,298,439	7,991,219	(1,307,220)	(16.4%)
12,203,578	10,704,770	(1,498,808)	(14.0%)	Prescription Drugs	42,012,432	41,882,997	(129,435)	(0.3%)
612,767	580,496	(32,271)	(5.6%)	Incentive Payments	2,847,300	2,472,332	(374,968)	(15.2%)
980,845	1,531,482	550,637	36.0%	Medical Management	4,098,340	6,033,049	1,934,709	32.1%
841,770	112,540	(729,230)	(648.0%)	Other Medical Expenses	2,354,624	448,659	(1,905,965)	(424.8%)
35,785,139	**36,192,477**	**407,338**	**1.1%**	**Total Medical Expenses**	**137,940,870**	**143,574,326**	**5,633,456**	**3.9%**
1,321,717	**832,910**	**488,807**	**58.7%**	**Gross Margin**	**6,473,118**	**5,198,575**	**1,274,543**	**24.5%**
				Administrative Expenses				
1,076,245	1,228,608	152,363	12.4%	Salaries, Wages & Employee Benefits	4,099,216	4,800,566	701,350	14.6%
338,765	117,716	(221,049)	(187.8%)	Professional Fees	451,654	470,864	19,210	4.1%
84,661	459,323	374,662	81.6%	Purchased Services	1,066,261	1,773,656	707,395	39.9%
220,971	121,107	(99,864)	(82.5%)	Printing & Postage	446,118	484,428	38,310	7.9%
118,827	112,453	(6,374)	(5.7%)	Other Operating Expenses	411,348	463,448	52,100	11.2%
926,722	1,198,167	271,445	22.7%	Indirect Cost Allocation, Occupancy	3,706,887	4,792,668	1,085,781	22.7%
2,766,190	**3,237,374**	**471,184**	**14.6%**	**Total Administrative Expenses**	**10,181,484**	**12,785,630**	**2,604,146**	**20.4%**
(1,444,473)	(2,404,464)	**959,991**	**39.9%**	**Change in Net Assets**	(3,708,366)	(7,587,055)	**3,878,689**	**51.1%**
96.4%	***97.8%***	(1.3%)		***Medical Loss Ratio***	***95.5%***	***96.5%***	(1.0%)	
7.5%	***8.7%***	***1.3%***		***Admin Loss Ratio***	***7.1%***	***8.6%***	***1.5%***	

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ONECARE INCOME STATEMENT– OCTOBER MONTH:

REVENUES are $37.1 million, favorable to budget $0.1 million:

- Favorable volume related variance of $0.8 million
- Unfavorable price related variance of $0.7 million

MEDICAL EXPENSES are $35.8 million, favorable to budget $0.4 million:

- Unfavorable volume related variance of $0.8 million
- Favorable price related variance of $1.2 million
  - Provider Capitation expense favorable variance of $1.9 million
  - Facilities Claims expense favorable variance of $1.0 million
  - Medical Management expense favorable variance of $0.6 million
  - Offset by:
    - Prescription Drugs expense unfavorable variance of $1.3 million
    - Other Medical Expenses unfavorable variance of $0.7 million
    - Professional Claims expense unfavorable variance of $0.2 million

ADMINISTRATIVE EXPENSES are $2.8 million, favorable to budget $0.5 million

- Non-Salary expense favorable to budget $0.3 million
- Salaries, Wages & Employee Benefits expense favorable to budget $0.2 million

CHANGE IN NET ASSETS is ($1.4) million, favorable to budget $1.0 million

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
536	**541**	(5)	(0.9%)	**Member Months**	**2,122**	**2,140**	(18)	(0.8%)
				Revenues				
3,675,888	3,696,108	(20,221)	(0.5%)	Medi-Cal Capitation Revenue	14,536,964	14,620,464	(83,500)	(0.6%)
822,024	817,763	4,261	0.5%	Medicare Part C Revenue	3,297,051	3,277,049	20,002	0.6%
451,299	325,132	126,167	38.8%	Medicare Part D Revenue	1,537,565	1,293,346	244,219	18.9%
4,949,210	**4,839,003**	**110,207**	**2.3%**	**Total Operating Revenue**	**19,371,581**	**19,190,859**	**180,722**	**0.9%**
				Medical Expenses				
1,461,370	1,610,531	149,161	9.3%	Medical Management	5,726,200	6,346,265	620,065	9.8%
767,444	841,998	74,554	8.9%	Facilities Claims	3,676,451	3,277,540	(398,911)	(12.2%)
804,908	794,924	(9,984)	(1.3%)	Professional Claims	3,295,458	3,093,561	(201,897)	(6.5%)
629,466	730,319	100,853	13.8%	Prescription Drugs	2,387,020	2,842,738	455,718	16.0%
59,014	40,113	(18,901)	(47.1%)	MLTSS	180,833	147,830	(33,003)	(22.3%)
298,099	286,213	(11,886)	(4.2%)	Patient Transportation	1,209,141	1,106,190	(102,951)	(9.3%)
4,020,300	**4,304,098**	**283,798**	**6.6%**	**Total Medical Expenses**	**16,475,102**	**16,814,124**	**339,022**	**2.0%**
928,910	**534,905**	**394,005**	**73.7%**	**Gross Margin**	**2,896,478**	**2,376,735**	**519,743**	**21.9%**
				Administrative Expenses				
190,669	188,864	(1,805)	(1.0%)	Salaries, Wages & Employee Benefits	739,558	740,293	735	0.1%
(31,353)	13,941	45,294	324.9%	Professional Fees	32,232	55,556	23,324	42.0%
52,257	69,662	17,405	25.0%	Purchased Services	285,873	278,648	(7,225)	(2.6%)
1,617	21,787	20,170	92.6%	Printing & Postage	52,094	87,148	35,054	40.2%
886	1,622	736	45.4%	Depreciation & Amortization	3,544	6,488	2,944	45.4%
11,762	11,112	(650)	(5.9%)	Other Operating Expenses	44,413	44,656	243	0.5%
14,716	17,494	2,778	15.9%	Indirect Cost Allocation, Occupancy	58,866	69,976	11,110	15.9%
240,556	**324,482**	**83,926**	**25.9%**	**Total Administrative Expenses**	**1,216,580**	**1,282,765**	**66,185**	**5.2%**
688,355	**210,423**	**477,932**	**227.1%**	**Change in Net Assets**	**1,679,899**	**1,093,970**	**585,929**	**53.6%**
81.2%	***88.9%***	(7.7%)		***Medical Loss Ratio***	***85.0%***	***87.6%***	(2.6%)	
4.9%	***6.7%***	***1.8%***		***Admin Loss Ratio***	***6.3%***	***6.7%***	***0.4%***	

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CalOptima Health
Multipurpose Senior Services Program (MSSP)
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
571	**558**	**13**	**2.3%**	**Member Months**	**2,231**	**2,232**	(1)	(0.0%)
				Revenues				
252,753	249,054	3,699	1.5%	Revenue	988,159	996,216	(8,057)	(0.8%)
252,753	**249,054**	**3,699**	**1.5%**	**Total Operating Revenue**	**988,159**	**996,216**	(8,057)	(0.8%)
				Medical Expenses				
201,765	194,133	(7,632)	(3.9%)	Medical Management	793,167	776,532	(16,635)	(2.1%)
37,057	32,959	(4,098)	(12.4%)	Waiver Services	142,668	131,836	(10,832)	(8.2%)
201,765	194,133	(7,632)	(3.9%)	Total Medical Management	793,167	776,532	(16,635)	(2.1%)
37,057	32,959	(4,098)	(12.4%)	Total Waiver Services	142,668	131,836	(10,832)	(8.2%)
238,822	**227,092**	(11,730)	(5.2%)	**Total Program Expenses**	**935,834**	**908,368**	(27,466)	(3.0%)
13,931	**21,962**	(8,031)	(36.6%)	**Gross Margin**	**52,325**	**87,848**	(35,523)	(40.4%)
				Administrative Expenses				
92,121	126,129	34,008	27.0%	Salaries, Wages & Employee Benefits	382,319	495,656	113,337	22.9%
1,457	1,500	43	2.9%	Professional Fees	5,828	6,000	172	2.9%
2	-	(2)	(100.0%)	Purchased Services	24	-	(24)	(100.0%)
10,099	8,520	(1,579)	(18.5%)	Other Operating Expenses	28,995	34,080	5,085	14.9%
6,351	7,583	1,232	16.2%	Indirect Cost Allocation, Occupancy	25,404	30,332	4,928	16.2%
110,031	**143,732**	**33,701**	**23.4%**	**Total Administrative Expenses**	**442,571**	**566,068**	**123,497**	**21.8%**
(96,100)	(121,770)	**25,670**	**21.1%**	**Change in Net Assets**	(390,246)	(478,220)	**87,974**	**18.4%**
94.5%	***91.2%***	***3.3%***		***Medical Loss Ratio***	***94.7%***	***91.2%***	***3.5%***	
43.5%	***57.7%***	***14.2%***		***Admin Loss Ratio***	***44.8%***	***56.8%***	***12.0%***	

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CalOptima Health
Covered CA
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2025

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
-	**-**	**-**	**0.0%**	**Member Months**	**-**	**-**	**-**	**0.0%**
				Revenues				
-	-	-	0.0%	Medi-Cal Capitation Revenue	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Medical Expenses				
-	44,984	44,984	100.0%	Medical Management	-	179,936	179,936	100.0%
-	**44,984**	**44,984**	**100.0%**	**Total Medical Expenses**	**-**	**179,936**	**179,936**	**100.0%**
-	(44,984)	**44,984**	(100.0%)	**Gross Margin**	**-**	(179,936)	**179,936**	(100.0%)
				Administrative Expenses				
68,211	346,711	278,501	80.3%	Salaries, Wages & Employee Benefits	265,315	1,091,521	826,206	75.7%
130,484	418,333	287,849	68.8%	Professional Fees	1,322,509	1,673,332	350,823	21.0%
-	52,000	52,000	100.0%	Purchased Services	-	208,000	208,000	100.0%
-	21	21	100.0%	Printing & Postage	-	84	84	100.0%
-	43,221	43,221	100.0%	Other Operating Expenses	-	172,884	172,884	100.0%
198,694	**860,286**	**661,592**	**76.9%**	**Total Administrative Expenses**	**1,587,824**	**3,145,821**	**1,557,997**	**49.5%**
				Non-Operating Income (Loss)				
-	-	-	0.0%	Net Operating Tax	-	-	-	0.0%
-	-	-	0.0%	Net QAF & IGT Income/Expense	-	-	-	0.0%
-	-	-	0.0%	Other Income/Expense	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Non-Operating Income (Loss)**	**-**	**-**	**-**	**0.0%**
(198,694)	(905,270)	**706,576**	**78.1%**	**Change in Net Assets**	(1,587,824)	(3,325,757)	**1,737,933**	**52.3%**
0.0%	***0.0%***	***0.0%***		***Medical Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	

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CalOptima Health
Building - 505 City Parkway
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2025

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				
89,443	29,708	(59,735)	(201.1%)	Purchased Services	268,755	118,832	(149,923)	(126.2%)
185,353	191,643	6,290	3.3%	Depreciation & Amortization	741,414	766,572	25,158	3.3%
23,371	25,124	1,753	7.0%	Insurance Expense	93,490	100,496	7,006	7.0%
183,459	219,809	36,350	16.5%	Repair & Maintenance	600,966	879,236	278,270	31.6%
26,991	59,093	32,102	54.3%	Other Operating Expenses	295,073	236,372	(58,701)	(24.8%)
(508,617)	(525,376)	(16,759)	(3.2%)	Indirect Cost Allocation, Occupancy	(1,999,698)	(2,101,504)	(101,806)	(4.8%)
-	**1**	**1**	**100.0%**	**Total Administrative Expenses**	**-**	**4**	**4**	**100.0%**
-	(1)	**1**	(100.0%)	**Change in Net Assets**	**-**	(4)	**4**	(100.0%)

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CalOptima Health
Building - 500 City Parkway
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
130,875	118,206	12,669	10.7%	Rental Income	523,502	472,824	50,678	10.7%
130,875	**118,206**	**12,669**	**10.7%**	**Total Operating Revenue**	**523,502**	**472,824**	**50,678**	**10.7%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
52,466	19,131	(33,335)	(174.2%)	Purchased Services	177,112	76,524	(100,588)	(131.4%)
58,871	75,663	16,792	22.2%	Depreciation & Amortization	236,313	302,652	66,339	21.9%
8,600	9,245	645	7.0%	Insurance Expense	34,398	36,980	2,582	7.0%
(100,274)	104,657	204,931	195.8%	Repair & Maintenance	124,402	418,628	294,226	70.3%
1,197	31,298	30,101	96.2%	Other Operating Expenses	108,978	125,192	16,214	13.0%
(6,132)	(25,416)	(19,284)	(75.9%)	Indirect Cost Allocation, Occupancy	(76,063)	(101,664)	(25,601)	(25.2%)
14,727	**214,578**	**199,851**	**93.1%**	**Total Administrative Expenses**	**605,140**	**858,312**	**253,172**	**29.5%**
116,148	(96,372)	**212,520**	**220.5%**	**Change in Net Assets**	(81,639)	(385,488)	**303,849**	**78.8%**

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CalOptima Health
Building - 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2025

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				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
8	-	(8)	(100.0%)	Printing & Postage	26	-	(26)	(100.0%)
35,054	3,333	(31,721)	(951.7%)	Purchased Services	136,528	13,332	(123,196)	(924.1%)
9,397	9,651	254	2.6%	Depreciation & Amortization	37,590	38,604	1,014	2.6%
1,498	28,533	27,035	94.8%	Repair & Maintenance	190	114,132	113,942	99.8%
(965)	720	1,685	234.0%	Other Operating Expenses	15,754	2,880	(12,874)	(447.0%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
44,991	**42,237**	(2,754)	(6.5%)	**Total Administrative Expenses**	**190,088**	**168,948**	(21,140)	(12.5%)
(44,991)	(42,237)	(2,754)	(6.5%)	**Change in Net Assets**	(190,088)	(168,948)	(21,140)	(12.5%)

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OTHER PROGRAM INCOME STATEMENTS – OCTOBER MONTH:

PACE

- **CHANGE IN NET ASSETS** is $0.7 million, favorable to budget $0.5 million

MSSP

- **CHANGE IN NET ASSETS** is ($96,100), favorable to budget $25,670

Covered CA

- **CHANGE IN NET ASSETS** is ($0.2) million, favorable to budget $0.7 million

NON-OPERATING INCOME STATEMENTS – OCTOBER MONTH:

BUILDING 500 City Parkway

- **CHANGE IN NET ASSETS** is $0.1 million, favorable to budget $0.2 million
  - Net of $130,875 in rental income and $14,727 in expenses

BUILDING 7900 Garden Grove Blvd

- **CHANGE IN NET ASSETS** is ($44,991), unfavorable to budget $2,754

INVESTMENT INCOME

- Favorable variance of $4.6 million compared to budget. Driven by investment income of $5.4 million, offset by net realized and unrealized loss of ($0.9) million

CalOptima Health
Balance Sheet
October 31, 2025

	October-25	September-25	$ Change	% Change
ASSETS				
Current Assets				
Cash and Cash Equivalents	324,574,430	529,228,976	(204,654,546)	(38.7%)
Short-term Investments	1,571,247,770	1,438,154,754	133,093,016	9.3%
Capitation Receivable	646,847,667	455,576,184	191,271,483	42.0%
Receivables - Other	89,486,350	86,563,533	2,922,817	3.4%
Prepaid Expenses	20,892,777	24,490,152	(3,597,375)	(14.7%)
Total Current Assets	**2,653,048,995**	**2,534,013,599**	**119,035,396**	**4.7%**
Board Designated Assets				
Board Designated Reserves	1,609,893,771	1,604,696,215	5,197,556	0.3%
Statutory Designated Reserves	134,630,744	134,144,257	486,487	0.4%
Total Designated Assets	**1,744,524,515**	**1,738,840,472**	**5,684,043**	**0.3%**
Restricted Deposit	**300,000**	**300,000**	**-**	**0.0%**
Capital Assets, Net	**110,981,980**	**102,831,594**	**8,150,386**	**7.9%**
Total Assets	**4,508,855,489**	**4,375,985,665**	**132,869,824**	**3.0%**
Deferred Outflows of Resources				
Advance Discretionary Payment	-	-	-	0.0%
Net Pension	27,437,072	27,437,072	-	0.0%
Other Postemployment Benefits	1,189,000	1,189,000	-	0.0%
Total Deferred Outflows of Resources	**28,626,072**	**28,626,072**	**-**	**0.0%**
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	**4,537,481,561**	**4,404,611,737**	**132,869,824**	**3.0%**
LIABILITIES				
Current Liabilities				
Accounts Payable	228,406,051	102,805,275	125,600,776	122.2%
Medical Claims Liability	1,028,364,899	1,052,501,127	(24,136,228)	(2.3%)
Accrued Payroll Liabilities	22,127,423	27,598,083	(5,470,660)	(19.8%)
Deferred Revenue	47,181,657	14,728,656	32,453,002	220.3%
Other Current Liabilities	-	-	-	0.0%
Capitation & Withholds	150,999,429	168,197,198	(17,197,769)	(10.2%)
Total Current Liabilities	**1,477,079,459**	**1,365,830,338**	**111,249,121**	**8.1%**
GASB 96 Subscription Liabilities	23,418,743	19,540,147	3,878,596	19.8%
Community Reinvestment	105,935,486	103,822,622	2,112,864	2.0%
Capital Lease Payable	229,567	233,561	(3,994)	(1.7%)
Postemployment Health Care Plan	17,336,844	17,312,195	24,649	0.1%
Net Pension Liability	5,840,992	5,840,992	-	0.0%
Total Liabilities	**1,629,841,091**	**1,512,579,855**	**117,261,237**	**7.8%**
Deferred Inflows of Resources				
Net Pension	1,321,519	1,321,519	-	0.0%
Other Postemployment Benefits	2,988,000	2,988,000	-	0.0%
Total Deferred Inflows of Resources	**4,309,519**	**4,309,519**	**-**	**0.0%**
Net Position				
Required TNE	132,360,378	131,812,377	548,001	0.4%
Funds in excess of TNE	2,770,970,573	2,755,909,986	15,060,587	0.5%
Total Net Position	**2,903,330,951**	**2,887,722,363**	**15,608,588**	**0.5%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION	**4,537,481,561**	**4,404,611,737**	**132,869,824**	**3.0%**

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BALANCE SHEET – OCTOBER MONTH:

ASSETS of $4.5 billion increased $132.9 million from September or 3.0%

- Capitation Receivables increased $191.3 million due primarily to Managed Care Organization (MCO) tax accruals
- Total Capital Assets increased $8.2 million due to the recording of two qualifying GASB 96 capitalized contracts
- Total Designated Assets increased $5.7 million due to interest income
- Operating Cash and Short-term Investments decreased $71.6 million due to outflows for July (MCO) taxes of $62.8 million, $23.9 million for the Medi-Cal Mental Health pay-for-value program, and one additional claims check run of $15.6 million, all offset by an increase of $30.5 million for the Centers for Medicare & Medicaid Services (CMS) prepaid November capitation

LIABILITIES of $1.6 billion increased $117.3 million from September or 7.8%

- Accounts Payable increased $125.6 million due to timing of MCO tax accruals
- Deferred Revenue increased $32.5 million due to the recognition of $32.4 million of November CMS revenue received in October
- Medical Claims Liabilities decreased $24.1 million due to variability in claims experience
- Capitation & Withholds decreased $17.2 million due to the payout of $23.75 million of quality incentives for measurement year 2024, offset by October Healthcare Effectiveness Data Information Set (HEDIS) and hospital reporting accruals

NET ASSETS of $2.9 billion, increased $15.6 million from September or 0.5%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of October 31, 2025

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	804,884,085				
MetLife Tier One	805,009,685				
Board Designated Reserves	1,609,893,771	1,087,894,962	1,740,631,940	521,998,808	(130,738,169)
Current Reserve Level (X months of average monthly revenue) [1]	*3.70*	*2.50*	*4.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	67,431,417				
MetLife Tier Two	67,199,327				
Statutory Designated Reserves	134,630,744	132,360,378	145,596,415	2,270,366	(10,965,672)
Current Reserve Level (X min. TNE) [1]	*1.02*	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

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CalOptima Health
Statement of Cash Flow
October 31, 2025

	October 2025	July - October 2025
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	15,608,588	102,747,250
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation & Amortization	1,296,175	4,475,785
Changes in assets and liabilities:		
Prepaid expenses and other	3,597,375	(9,709,715)
Capitation receivable	(194,194,300)	12,777,717
Medical claims liability	(24,136,228)	(19,372,440)
Deferred revenue	32,453,002	25,127,095
Payable to health networks	(17,197,769)	(2,993,936)
Accounts payable	125,600,776	(5,580,456)
Accrued payroll	(5,446,011)	(7,630,521)
Other accrued liabilities	5,987,467	24,402,932
Net cash provided by/(used in) operating activities	(56,430,926)	124,243,711
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	(133,093,016)	(230,321,169)
Change in Property and Equipment	(9,446,561)	(16,835,060)
Change in Restricted Deposit & Other	-	-
Change in Board Designated Reserve	(5,684,043)	(27,717,006)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	(148,223,620)	(274,873,236)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	(204,654,546)	(150,629,525)
CASH AND CASH EQUIVALENTS, beginning of period	529,228,976	475,203,955
CASH AND CASH EQUIVALENTS, end of period	**324,574,430**	**324,574,430**

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CalOptima Health
Spending Plan
For the Four Months Ending October 31, 2025

Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
Total Net Position @ 10/31/2025	**$2,903.3**			**100.0%**
Resources Assigned				
Board Designated Reserve[1]	**$1,609.9**			**55.4%**
Statutory Designated Reserve[1]	**$134.6**			**4.6%**
Capital Assets, net of Depreciation	**$111.0**			**3.8%**
Resources Allocated[3]				
Homeless Health Initiative[2]	$17.7	$65.8	$48.2	0.6%
Housing and Homelessness Incentive Program[2]	24.8	87.4	62.6	0.9%
Intergovernmental Transfers (IGT)[4]	39.3	52.1	12.8	1.4%
Digital Transformation and Workplace Modernization[3]	23.9	100.0	76.1	0.8%
CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
CalFresh and Redetermination Outreach Strategy	1.8	6.0	4.2	0.1%
Coalition of Orange County Community Health Centers Grant	25.7	50.0	24.3	0.9%
Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
General Awareness Campaign	0.4	4.7	4.3	0.0%
Member Health Needs Assessment	0.5	1.3	0.7	0.0%
Five-Year Hospital Quality Program Beginning MY 2023	116.6	153.5	36.9	4.0%
Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.3%
In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
National Alliance for Mental Illness Orange County Peer Support Program Grant	3.0	5.0	2.0	0.1%
Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
Wellness & Prevention Program Grant	1.3	2.7	1.4	0.0%
CalOptima Health Provider Workforce Development Fund Grant	43.3	50.0	6.7	1.5%
Distribution Event - Naloxone Grant	2.2	15.0	12.8	0.1%
Garden Grove Bldg. Improvement	9.7	10.5	0.8	0.3%
CalOptima Health Community Reinvestment Program	19.0	19.0	0.0	0.7%
Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
Outreach Strategy for newly eligible Adult Expansion members	1.1	6.8	5.8	0.0%
Quality Initiatives from unearned Pay for Value Program	18.1	23.3	5.2	0.6%
Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.0	1.0	1.0	0.0%
Medi-Cal Provider Rate Increases	245.6	526.2	280.6	8.5%
Homeless Prevention and Stabilization Pilot Program	0.2	0.3	0.1	0.0%
OneCare Member Engagement and Education	0.2	0.3	0.1	0.0%
Medi-Cal Eligibility Outreach Strategy	19.8	19.8	0.0	0.7%
Subtotal:	**$627.0**	**$1,236.4**	**$609.5**	**21.6%**
Resources Available for New Initiatives				
Unallocated/Unassigned[1]	**$420.9**			**14.5%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 183 days of CalOptima Health's current operations.

[2] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.

[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

[4] On June 5, 2025, the Board of Directors approved the close out of Board-approved initiatives and transfer of remaining funds back to unallocated reserves.

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CalOptima Health
Key Financial Indicators
As of October 31, 2025

	Item Name	October 2025 Actual	October 2025 Budget	October 2025 Variance	October 2025 %		July - October 2025 Actual	July - October 2025 Budget	July - October 2025 Variance	July - October 2025 %	
Income Statement	Member Months	877,802	894,351	(16,549)	(1.9%)		3,559,206	3,602,436	(43,230)	(1.2%)	
	Operating Revenue	391,534,915	393,262,363	(1,727,448)	(0.4%)		1,812,045,480	1,585,363,351	226,682,129	14.3%	
	Medical Expenses	364,202,932	370,044,385	5,841,453	1.6%		1,663,728,422	1,473,709,557	(190,018,865)	(12.9%)	
	General and Administrative Expense	21,603,398	25,771,359	4,167,961	16.2%		85,454,289	101,342,952	15,888,662	15.7%	
	Non-Operating Income/(Loss)	9,880,003	8,194,730	1,685,273	20.6%		39,884,481	32,778,920	7,105,561	21.7%	
	Summary of Income & Expenses	15,608,588	5,641,349	9,967,239	176.7%		102,747,250	43,089,762	59,657,488	138.4%	
Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	93.0%	94.1%	(1.1%)			91.8%	93.0%	(1.1%)		
	Administrative Loss Ratio (ALR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	5.5%	6.6%	1.0%			4.7%	6.4%	1.7%		

Key:

> 0%	
> -20%, < 0%	
< -20%	

Investment	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
	@10/31/2025	3,288,172,931	3,147,748,842	140,424,090	4.5%

Unallocated/Unassigned Reserve Balance	Current Month @ October 2025	Fiscal Year Ending June 2024	Change	%
Consolidated	420,781,042	264,975,684	155,805,357	58.8%
*Days Cash On Hand**	183			

*Total Designated Reserves and unallocated reserve amount can support approximately 183 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, 2025

	October 2025				July 2025 - October 2025				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	**1,698,005**	**365,262**	**(1,332,743)**	**(364.9%)**	**3,155,850**	**648,908**	**(2,506,942)**	**(386.3%)**	**18,766,802**	**27,419,024**	**8,652,222**	**31.6%**
Operating Expenses:												
Salaries, Wages & Benefits	-	-	-	0.0%	-	-	-	0.0%	17,826,058	17,826,058	-	0.0%
Professional Fees	(217,915)	250,000	467,915	187.2%	429,369	1,000,000	570,631	57.1%	7,230,180	7,800,811	570,631	7.3%
Purchased Services	(127,268)	-	127,268	0.0%	(118,906)	-	118,906	0.0%	1,213,763	1,332,669	118,906	8.9%
GASB 96 Amortization Expenses	-	-	-	0.0%	-	-	-	0.0%	2,563,169	2,563,169	-	0.0%
Other Expenses	574,965	182,292	(392,673)	(215.4%)	1,882,041	729,168	(1,152,873)	(158.1%)	22,977,782	21,824,909	(1,152,873)	(5.3%)
Medical Management	0	-	0	0.0%	-	-	-	0.0%	5,502,156	5,502,156	-	0.0%
Total Operating Expenses	**229,783**	**432,292**	**202,509**	**46.8%**	**2,192,504**	**1,729,168**	**(463,336)**	**(26.8%)**	**57,313,109**	**56,849,774**	**(463,336)**	**(0.8%)**

Funding Balance Tracking:	Approved Budget	Actual Spend	Variance
Beginning Funding Balance	100,000,000	100,000,000	-
Less:			
Capital Assets[1]	38,931,116	18,766,802	20,164,314
FY2023 Operating Budget[2]	8,381,011	8,381,011	-
FY2024 Operating Budget	22,788,092	22,788,092	-
FY2025 Operating Budget	24,289,000	23,951,502	337,498
FY2026 Operating Budget	5,187,500	2,192,504	2,994,996
Ending Funding Balance	**423,281**	**23,920,089**	**23,496,808**
Add: Prior year unspent Operating Budget	**337,498**		
Total Available Funding	**760,779**		

[1] Staff will continue to monitor the project status of DTS' Capital Assets.
[2] Unspent budget from this period is added back to available DTS funding.
[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

Note: Report includes applicable transactions for GASB 96, Subscriptions - Based Information Technology Arrangements.

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CalOptima Health
Summary of Homeless Health Initiatives (HHI) and Allocated Funds
As of October 31, 2025

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
HHI - IGT'S	64,033,726	64,033,726	48,151,228	15,882,498	-
HHI - Existing Reserves	1,800,000	1,800,000	-	1,800,000	-
HHIP	40,100,000	40,100,000	-	40,100,000	-
Total	**105,933,726**	**105,933,726**	**48,151,228**	**57,782,498**	**-**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-	IGT's
Recuperative Care	6,194,190	6,194,190	-	IGT's
Medical Respite	250,000	250,000	-	IGT's
Day Habilitation (County for HomeKey)	2,500,000	-	2,500,000	IGT's
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-	IGT's
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-	IGT's
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522	IGT's
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	925,540	37,721	IGT's
FQHC (Community Health Center) Expansion	21,902	21,902	-	IGT's
HCAP and CalOptima Health Days	9,888,914	4,705,022	5,183,892	IGT's
Vaccination Intervention and Member Incentive Strategy[2]	54,649	54,649	-	IGT's
Street Medicine[1]	14,279,077	9,085,700	5,193,377	IGT's & Existing Reserves
Outreach and Engagement	7,000,000	2,276,015	4,723,985	IGT's
Housing and Homelessness Incentive Program (HHIP)[3]	40,100,000	-	40,100,000	IGT's & Existing Reserves
Subtotal of Approved Initiatives	**105,933,726**	**48,151,228**	**57,782,497**	
Transfer of funds to HHIP[3]	(40,100,000)	-	(40,100,000)	
Program Total	**65,833,726**	**48,151,228**	**17,682,497**	

[1]On August 7, 2025, CalOptima Health's Board of Directors approved $9.3 million to expand the Street Medicine Program - $3.2 million remaining from Street Medicine Initiative (from the Homeless Health Initiatives Reserve), $1.8 million from Existing Reserves, and $4.3 million from Intergovernmental Transfer balance resulting from a June 5, 2025, Board of of Director action, to fund 2-year grant agreements to Healthcare in Action (Anaheim), Celebrating Life Community Health Center (Costa Mesa), and AltaMed (Santa Ana).

[2]On June 5, 2025 the Board of Directors approved the close out of the Vaccination Intervention and Member Incentive Strategy program and transfer of the remaining funds of $68,699 to unallocated reserves for new initiatives.

[3]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP.

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CalOptima Health

Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds

As of October 31, 2025

Summary by Funding Source:	Total Funds[1]	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	72,931,189	32,995,535	39,935,654	$18,000,195
Existing Reserves & HHI Transfer	87,384,530	87,384,530	62,633,259	24,751,271	-
Total	**160,315,719**	**160,315,719**	**95,628,794**	**64,686,926**	**18,000,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	882,700	517,300	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,871,311	3,721,311	1,150,001	HHI & DHCS
Infrastructure Projects	5,832,314	5,698,977	133,337	HHI
Capital Projects	123,497,564	74,146,735	49,350,829	HHI, DHCS & Existing Reserves
System Change Projects	21,814,530	8,323,680	13,490,850	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	**$160,315,719[1]**	**$95,628,794**	**64,686,926**	

[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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CalOptima Health
Fiscal Year 2025-26 Budget Allocation Changes
Reporting Changes as of October 31, 2025

Transfer Month	Line of Business	From	To	Amount	Reason to Re-Allocate Funds
July	Medi-Cal	Human Resources - Training & Seminar - New: 7 Habits of Highly Effective People	Human Resources - Cert./Cont. Education - Educational Reimbursement	$90,000	For Educational Reimbursement
July	Medi-Cal	Human Resources - Professional Fees - Executive Recruiters, Direct Hire & Conversion Fees	Human Resources - Advertising - Combined: Recruitment & Job Postings Network	$90,000	For LinkedIn Advertising
July	Medi-Cal	IS - Infrastructure - Maintenance HW/SW - Oracle Software License	IS - Infrastructure - Maintenance HW/SW - Server - HP Server Maintenance	$28,150	For HP Maintenance Coverage
July	Medi-Cal	IS - Application Development - Prof Fees - Development and QA Professional Services	IS - Application Development - Purch Svcs - General - Managed Services for Website Support	$120,250	For American Eagle maintenance support
August	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Oracle Software License	ITS - Infrastructure - Other Operating Expenses - Server - VMWare	$140,238	For VMWare
August	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Palo Alto Firewall	ITS - Infrastructure - Professional Fees - IT Advisory Subscription	$162,890	For Professional Services
August	Medi-Cal	ITS - Application Development - Automation Application for the Board and Committee Material Preparation	ITS - Application Development - Policies and Regulation Compliance Identification - Readily Compliance Project	$65,000	For Readily Compliance Project
September	Medi-Cal	ITS - Infrastructure - Maintenance HW/SW Network Connectivity Maintenance and Support	ITS - Infrastructure - Maintenance HW/SW Maintenance of Operations and Desktop	$52,420	For Right Fax.
September	Medi-Cal	Customer Service - Member Communication	Human Resources - Consulting / Professional Fees	$70,000	For leadership development
October	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Microsoft True-Up	ITS - Infrastructure - Other Operating Expenses - Network - Solar Winds	$34,415	For On-Premise and cloud database monitoring maintenance
October	Medi-Cal	ITS - Infrastructure - Other Operating Expense - Microsoft Enterprise License Agreement (EA)	ITS - Applications Management - GASB 96 - Interest - Dell	$41,558	For Microsoft Enterprise License Agreement Renewal
October	Medi-Cal	ITS - Applications Management - GASB 96 - Interest - Dell	ITS - Applications Management - Other Operating Expenses - Flexera	$41,558	For increase against original contract
October	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Microsoft True-Up	ITS - Applications Management - Other Operating Expenses - TeamDynamix	$26,780	For TeamDynamix Solutions

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.

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Board of Directors Meeting
December 4, 2025

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima Health's Board of Directors including, but not limited to, updates on internal and health network monitoring and audits conducted by CalOptima Health's Delegation Oversight and Internal Audit departments, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. UPDATES ON REGULATORY AUDITS

1. Medicare

a. Calendar Year (CY) 2019 Part C Risk Adjustment Data Validation (RADV) Audit (CON19 RADV) *(applicable to OneCare)*

Update

- Medical records have been reviewed, validated and submitted to Centers for Medicare & Medicaid (CMS). Awaiting review from CMS and next steps.

Previously Reported

- June 12, 2025 - CMS notified CalOptima Health its OneCare contract (H5433) had been selected for a Payment Year (PY) 2019 Contract-Level Risk Adjustment Data Validation (CON19 RADV) audit.
- CMS will be conducting a medical record review to validate the accuracy of a subset of PY 2019 risk adjustment data and payments associated with encounters with dates of service from January 1, 2018, through December 31, 2018.
- Medical record submission window extended to November 10, 2025. Previous due date September 15, 2025.

Background

- The PY 2019 RADV audit will focus on risk adjusted payments made to Medicare Advantage Organizations (MAO) for the 2019 coverage year that CMS believes may be at higher risk for overpayments.

b. Annual Compliance Program Effectiveness (CPE) Audit (*applicable to OneCare)*

Update

- October 24, 2025 – Draft Audit Report received. There was one observation noted, and no findings.
- 11/3/25 – Comments to the draft audit report including a rebuttal to the observation were submitted to the auditor.

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Final audit report due by November 10, 2025.

Previously Reported

- Kick off meeting conducted 8/6/25.
- Audit Webinar Week 10/6/25 – 10/10/25.
- October 1, 2025 – Cases selected by the auditor for presentation of the process flow for management of specific compliance issues (tracers) presentation and associated attachments were submitted to the auditor.

Background

- CalOptima Health is required to conduct an independent audit on the effectiveness of its Compliance program on an annual basis, and to share the results with the governing body.
- CalOptima Health engaged an independent consultant to conduct the audit to ensure that its Compliance Program is administering the elements of an effective compliance program as outlines in the CMS Medicare Part C and D Program Audit Protocols.
- The audit will start in early August, 2025 and continue through November, 2025.
- The audit review period will be from 2/3/25 through 8/1/25.

c. Calendar Year (CY) 2024 Centers for Medicare & Medicaid (CMS) Financial Audit *(applicable to PACE)*

Update

- 10/25/25 – Entrance conference with CPA firm to kick-off the audit.
- 30-day audit deliverables are currently being reviewed for submission. Due to the auditor by November 7, 2025.
- 60-day audit deliverables are due by December 1, 2025.

Previously Reported

- 9/24/25 - Contract selection received.
- 9/30/25 – Certified Public Accounting (CPA) firm selected by CMS.
- 10/1/25 – Document Request List received from CPA firm to begin the audit process.
- 10/2/25 – Audit workplan and documents request distributed to impacted departments.

Background

- At least one-third of Medicare Advantage Organizations (MAOs) are selected for the annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CMS will audit and inspect any books and records of the MAO that pertain to 1) the ability of the organization to bear the risk of potential financial losses, or 2) services performed or determinations of amounts payable under the contract. The Pharmacy Benefit Management (PBM) company will also be required to provide CMS with all requested supporting documentation for this audit.
- CMS contracted with Myers and Stauffer to conduct the audit. Myers and Stauffer will act in the capacity of CMS agents and request records and supporting documentation for, but not limited to, the following items:
  - Claims data
  - Solvency
  - Enrollment

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- Base year entries on the bids
- Medical and/or drug expenses
- Related party transactions
- General administrative expenses
- Direct and Indirect Remuneration (DIR)

2. Medi-Cal

a. <u>2025 Department of Health Care Services (DHCS) Routine Medical Audit</u>

<u>No New Updates as of the last report.</u>

<u>Previously reported (still current)</u>

- 10/1/25: **DHCS has accepted 2 of the 4 Final Corrective Action Plans (CAPs)**.
- The status of the remaining 2 open CAPs is as follows:
  - 1 CAP is Partially Accepted: DHCS requested additional information that was submitted on 10/1/25.
  - 1 CAP is under DHCS review: No additional information has been requested, and no outstanding deliverables are due.
- **At this time, no additional deliverables are due to DHCS.**

<u>Audit Details and Background – previously reported</u>

- 8/1/25: Final CAP updates & deliverables submitted to DHCS
- 6/26/25: CalOptima Health submitted its timely CAP response to DHCS.
  - DHCS accepted 1 of the 4 CAPs; 3 CAPs remained open until additional information and future deliverables were provided.
- The DHCS Routine Medical Audit consisted of DHCS's review of both the Primary (aka "Main Contract") and Secondary contracts (aka "State Supported Services"). The report findings are as follows:
  - **Primary/Main Contract**
    - **4 Findings** across 3 audit categories.

Category #	Audit Area	# of Findings
1	Utilization Management	1
2	Case Management and Coordination of Care	2
3	Network and Access to Care	0
4	Member's Rights	0
5	Quality Management	0
6	Administrative and Organizational Capacity	1

  - **Secondary Contract - State Supported Services (SSS)**
    - **No Findings**

- October 23, 2024 – DHCS engaged CalOptima Health in its annual, routine medical audit.
  - The audit consisted of an evaluation of CalOptima Health's compliance with its contract and regulations in six (6) categories:

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- Utilization Management (UM)
- Case management and coordination of care
  - New area audited in this category:
    - Enhanced Care Management (ECM)
- Availability and accessibility
- Member's rights
- Quality management
- Administrative and organizational capacity
  - New area audited in this category:
    - Encounters

- New areas audited
  - Enhanced Care Management (ECM)
  - Encounters
- The audit was considered a limited-scope audit and required the participation of two (2) CalOptima Health Networks: Children's Hospital of Orange County Health Alliance (CHOC) and Optum for UM only
- Onsite interviews were conducted with CalOptima Health staff, including Medical Director, Director of Quality Management, Director of Utilization Management, Member Services Manager, Provider Relations Manager, Health Education Coordinator, Grievance Coordinator, and other staff as necessary.
- The audit involved a review of pre-onsite documents, staff interviews and medical record review.

- January 27, 2025 through January 29, 2025 – DHCS conducted the onsite visit with an Entrance Conference and conducted staff interviews throughout the rest of the onsite visit.
- 5/27/25: DHCS finalized its draft report and CalOptima Health received its formal CAP Request from DHCS.
  - The report was consistent with the draft report with four findings.

B. REGULATORY NOTICES OF NON-COMPLIANCE

- Department of Health Care Services (DHCS) Quality Sanction
  - On October 16, 2025, the DHCS issued a **notice of imposition of monetary sanctions** to CalOptima Health in the amount of $25,000 for failure to meet and exceed required Managed Care Accountability Set (MCAS) performance measures for Measurement Year (MY) 2024.
  - DHCS identified three (3) measures in which CalOptima Health did not meet the required minimum performance levels (MPLs):
    - Chronic Disease Management: Asthma Medication Ratio (AMR)
    - Behavioral Health: Follow-up After Emergency Department Visit for Mental Illness (FUM) – 30 days
    - Behavioral Health: Follow-up After Emergency Department Visit for Substance Use (FUA) – 30 days
  - Given the scope, gravity and ongoing performance on the MPL, DHCS has issued the minimum sanction amount to CalOptima Health.
  - DHCS requires written requests to meet and confer to be made within two (2) business days of receiving the notice. **CalOptima Health determined that a meet and confer with DHCS was not necessary.**

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- CalOptima Health is awaiting the Final Notice of Monetary Sanction Letter, which will include payment instructions.

C. UPDATES ON HEALTH NETWORK MONITORING AND AUDITS

- Optum Health Network – Lookback period August 1, 2024 to July 31, 2025 (Annual Audit webinar week October 14, 2025 – October 17, 2025).

D. INTERNAL AUDIT DEPARTMENT (IAD)

a. Internal Annual Audits in Process

- 2025 Claims Administration (Medi-Cal)
- 2025 Claims Administration (OneCare)
- 2025 Utilization Management (Medi-Cal)
- 2025 Utilization Management (OneCare)
- 2025 Pharmacy ODAG Part B (OneCare)
- 2025 Grievance and Appeals (OneCare)

b. Ad Hoc Internal Audits

- CalAIM Community Supports Housing Transition Navigation Services
- CalAIM Community Supports Program Oversight Practices

c. Board-Approved Grants Review

Grants currently under review include:

- Be Well/Mind OC, Irvine
- Coalition of Orange County Community Health Centers, MAT (Medication Assisted Treatment) Connect
- CalAIM Enhanced Care Management (ECM) Incentive Payment Program (IPP) Payment Grants
  - Talbert/Optum
- 2023 ECM Academy Cohort 2 Grants
  - 923
  - Casa de la Familia
  - Central County Senior Services, LLC, dba Alzheimer's Orange County
  - Children's Hospital Los Angeles
  - Community Action Partnership of Orange County (CAPOC)
  - Global Transitional Care, Inc.
  - Mariposa Women and Family Center
  - Maximon Behavioral Health, dba Mindful Living Center LLC
  - MOMS Orange County
  - Olive Crest
  - Serve the People Community Health Center
  - South Coast
  - Sowing Seeds Health, Inc.
  - Western Youth Services (WYS)
  - Pathways Community Services/Clarvida

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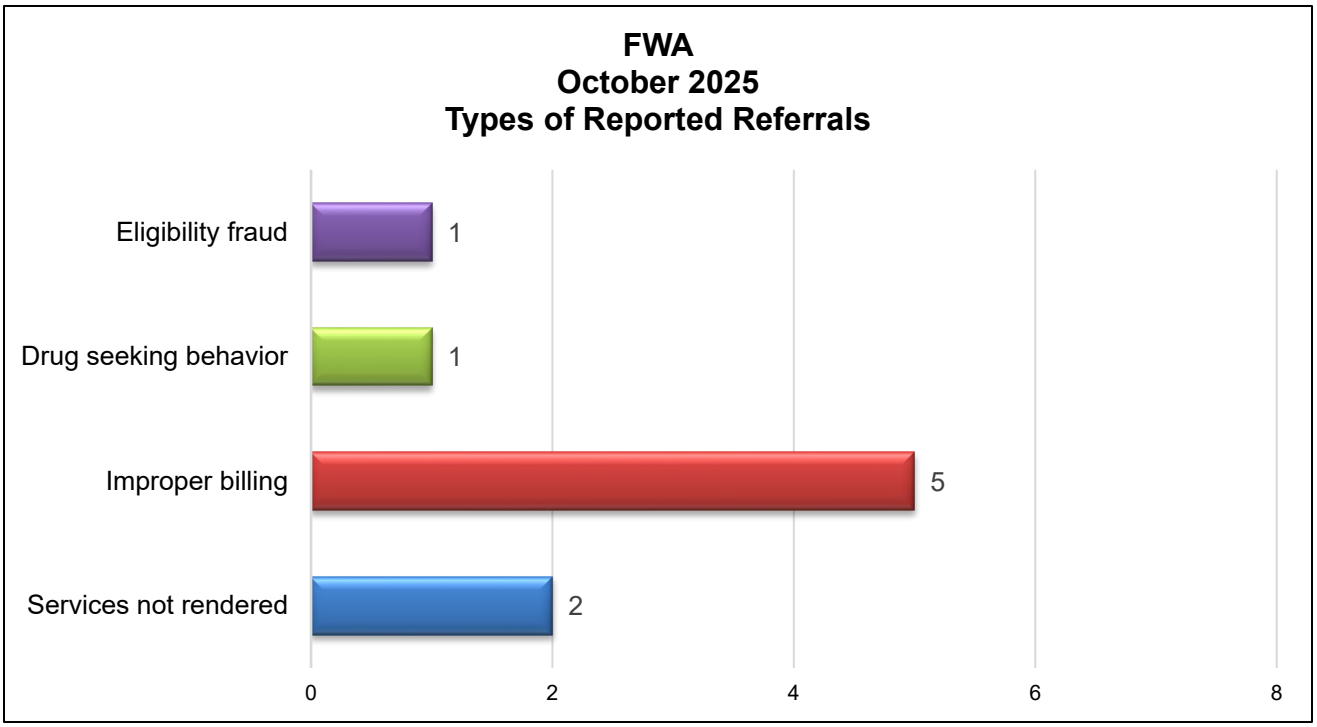
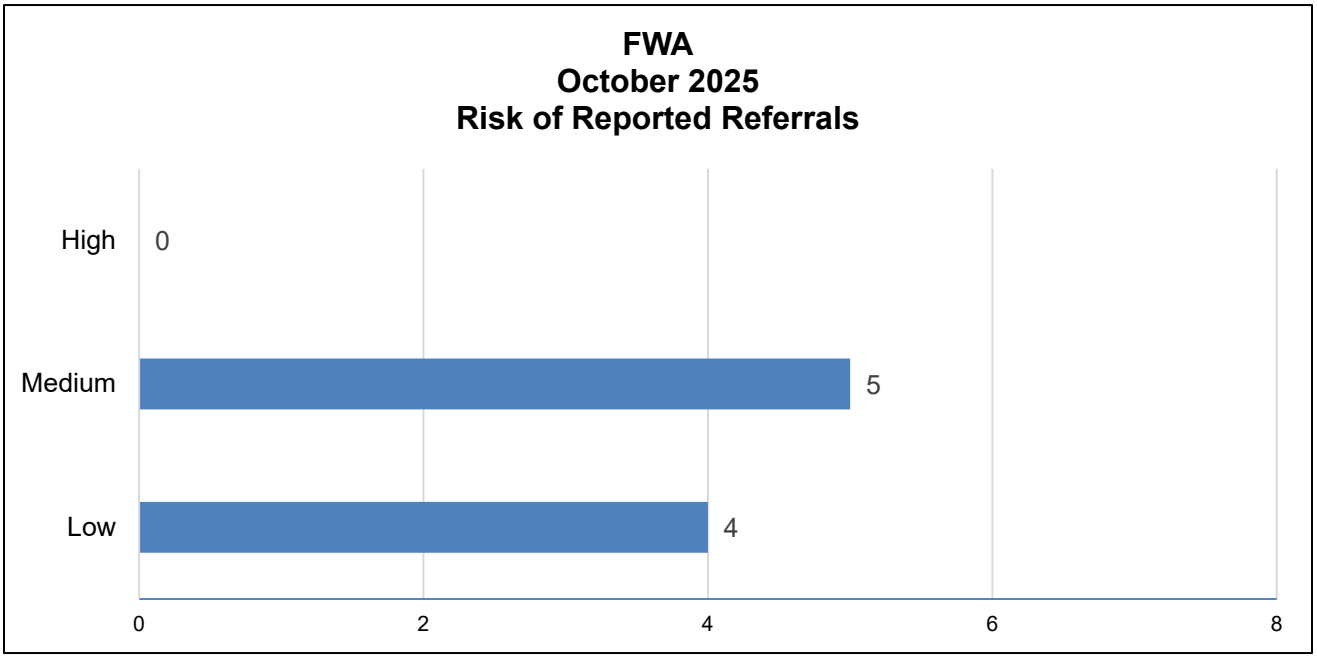
E. FRAUD, WASTE & ABUSE (FWA) INVESTIGATIONS





Total Number of New Cases Referred to DHCS (State)	9
Total Number of New Cases Referred to DHCS and CMS	7
Total Number of Referrals Reported	**9**

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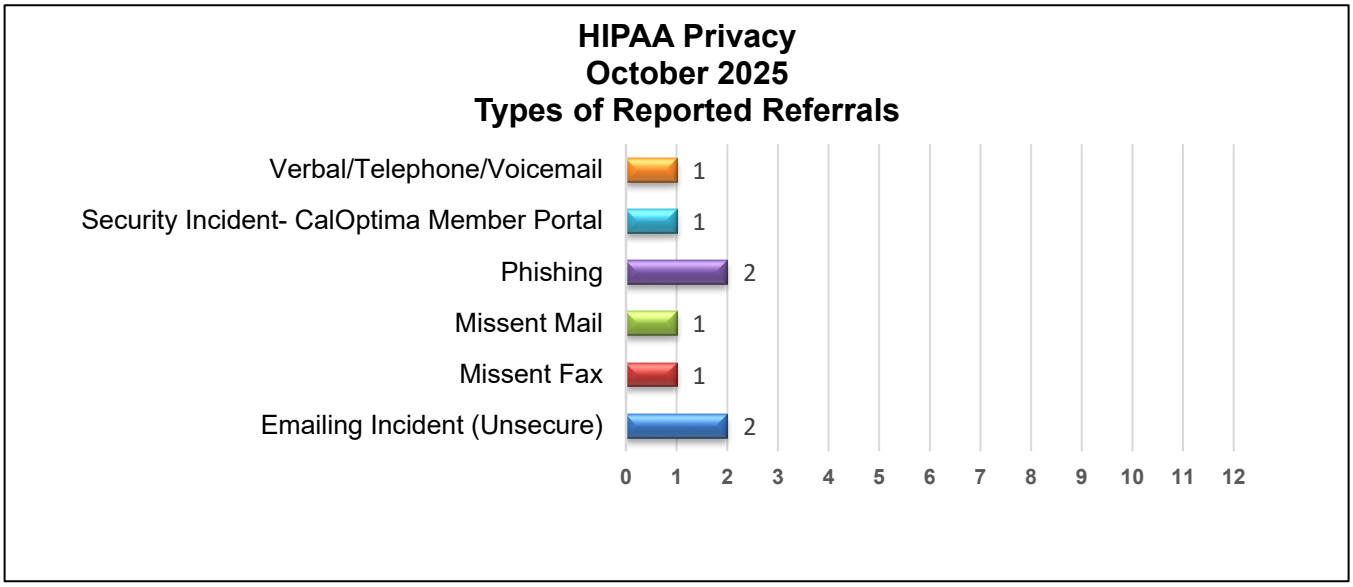
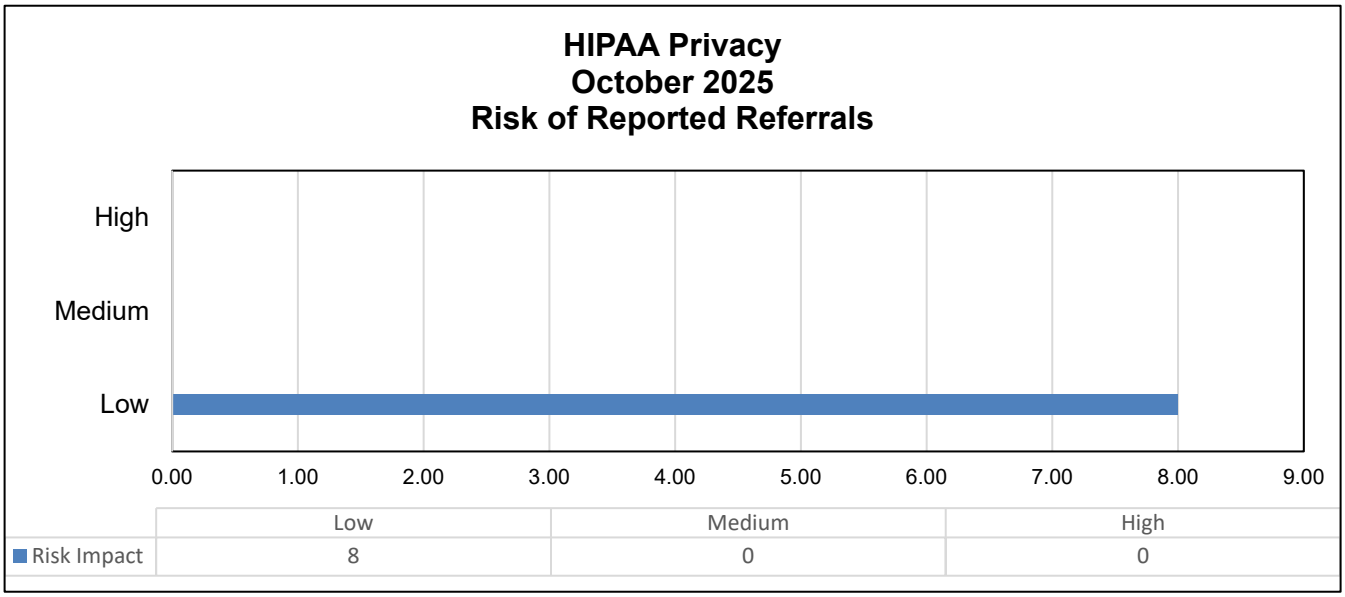
F. PRIVACY UPDATE





Total Number of Referrals Reported to DHCS (State)	8
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

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CHAMBER HILL

MEMORANDUM

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TO: CalOptima Health
Board of Directors

FROM: Chamber Hill Strategies

DATE: November 20, 2025

SUBJECT: Board of Directors Report – December 2025

CalOptima Health, Chamber Hill Strategies Meet with Lawmakers
CalOptima Health executives Jordan Abushawish and Donovan Higbee joined Chamber Hill Strategies on Capitol Hill for meetings with the Orange County delegation and key Republican offices outside of the delegation. Meetings included the offices of Sen. Adam Schiff (D-CA), Sen. Alex Padilla (D-CA), Rep. Lou Correa (D-CA-46), Rep. Derek Tran (D-CA-45), Rep. Young Kim (R-CA-40), Rep. David Valadao (R-CA-22), Rep. Dave Min (D-CA-47), Rep. Linda Sánchez (D-CA-38), Rep. Mike Levin (D-CA-49), Rep. Pete Aguilar (D-CA-33) Sen. Bill Cassidy (R-LA), Rep. John Joyce (R-PA-13), Rep. Vern Buchanan (R-FL-16), and the House Energy and Commerce Committee. They discussed the $7 million investment from CalOptima Health during the pause in SNAP benefits, the importance of extending the enhanced Advance Premium Tax Credits (APTCs) past December 31, and the anticipated challenges of implementing the Medicaid work requirements and six-month eligibility redeterminations. They underscored the need for adequate time and resources. The delegation reiterated their support for extending the enhanced APTCs and would provide any updates on rulemaking activity on the changes to Medicaid as they were aware. The Republican offices outside of the delegation appreciated hearing CalOptima Health's insights and welcomed continued discussions as guidance is released.

Government Shutdown Ends
The federal government shutdown formally ended on November 12 after the Senate brokered a compromise to fund three agencies through September 30, 2026, fund nine agencies and extend certain expiring health policies through January 30, 2026, and reinstate back pay for furloughed workers. From a political lens, the Republicans can be viewed as having "won" the shutdown in that the reopening did not require policy concessions that Democrats had sought (notably a clean extension of the enhanced APTCs tied to the Affordable Care Act marketplace). However, Democrats secured a promise of a December vote in the Senate on APTCs which are set to expire December 31, 2025.

House is Back in Session After Extended Recess
Following weeks of being out of session, the House of Representatives returned to more regular legislative operations immediately after the funding deal. New Rep. Adelita Grijalva (D-AZ) was sworn in, leaving the party breakdown as 219 Republicans to 214 Democrats. The House Ways and Means Subcommittee on Health held a hearing on November 19 titled "Modernizing Care Coordination to Prevent and Treat Chronic Disease." Witnesses described major gaps in chronic disease management, with particular

emphasis on diabetes, cardiovascular disease, behavioral health comorbidities, and the role of Medicare Advantage supplemental benefits.

APTC Extension Fight Heats Up

The debate over extending the enhanced APTCs intensified sharply after the shutdown ended. Senate and House Democrats have coalesced around trying to extend current policy without any modifications through December 31, 2026. During a highly publicized Senate hearing on November 19, Sen. Thom Tillis (R-NC) broke with his party by publicly calling for a one-year extension, arguing that marketplace stability should not be compromised during a period of elevated inflation and redetermination-related churn. Some House Republicans, including Rep. Young Kim (R-CA), have signaled their support for this position by cosponsoring a House bill to that effect.

Outlook for APTC Extension Remains Unclear

Notwithstanding the support of some Republicans, there is currently not enough support in the Senate to clear the 60-vote threshold for a one-year extension. Some Republicans, including Sen. Bill Cassidy (R-LA), Dan Sullivan (R-AK), and Mike Rounds (R-SD) are part of a Republican working group exploring a "change and extend" option which would extend the enhanced APTCs with modifications, including imposing an income cap, preventing improper payment of APTCs, and redirecting subsidy dollars to individuals via health savings accounts (HSAs). President Trump has posted repeatedly that he opposes a "clean" extension of the enhanced APTCs, and that he wants subsidies restructured through expanded HSA eligibility, describing HSAs as "the best way to give Americans control over their own health dollars."

Preliminary Guidance on Medicaid Provider Taxes is Released

The Centers for Medicare and Medicaid Services (CMS) sent a preliminary guidance letter to the States on implementing the Medicaid provider tax changes from the One Big Beautiful Bill Act. For expansion states like California, the allowable provider tax threshold will phase down between FY 2028 and FY 2032, ultimately reaching 3.5%. CMS will only recognize a tax as allowable if it was both legislatively authorized (and, if needed, waiver-approved) and actually generated revenue by July 4, 2025. The letter also separately eliminates tax structures that shift disproportionate costs to the federal government—such as rates far higher on Medicaid units—and requires states to correct non-compliant Managed Care Organization (MCO) taxes by FY 2026 and other provider taxes by FY 2028. Together, these provisions require all provider taxes to meet both the new thresholds and the updated "generally redistributive" rules, with CMS indicating that most fixes should be achievable within the new limits.

Public Charge Rule is Proposed

The Department of Homeland Security (DHS) published a proposed rule rescinding the 2022 public charge ground of inadmissibility regulations issued by the Biden Administration. In order to receive green card status, DHS proposes updated evidentiary standards that require detailed disclosures from immigrants about income, assets, liabilities, credit history, health conditions, household size, and benefit use—including non-cash programs such as Medicaid. Applications may be evaluated using weighted negative factors such as benefit receipt, poor health combined with lack of insurance, limited English proficiency, and limited financial reserves. Positive factors may include high income, private health insurance, strong employment history, and education or skills. The first Trump Administration attempted to finalize similar proposals in 2019 but received significant backlash and abandoned their efforts.

CALOPTIMA HEALTH - STATE LEGISLATIVE REPORT
November 24, 2025

General Update

Senate Leadership Changeover – On November 17, the gavel of the Senate President pro Tempore was passed to Senator Monique Limón (D–Santa Barbara) by former Pro Tem Mike McGuire (D–Healdsburg), who has since announced his candidacy for Congress. Limón has recently faced scrutiny over SB 158, a 2025 budget trailer bill she helped craft that included a narrowly tailored provision exempting certain housing projects from streamlined CEQA review. The Santa Barbara developer affected by the provision has filed a federal lawsuit, alleging the language unlawfully targets a single project and violates the equal protection clauses of the U.S. and California Constitutions. This issue is expected to continue evolving.

Rumors have also circulated regarding Limón's prospective leadership team, which is expected to include: Senator Angelique Ashby (D-Sacramento) as Appropriations Chair, Senator Christopher Cabaldon (D-West Sacramento) as Budget Chair, Senator Dr. Akilah Weber Pearson (D-San Diego) as Health Chair, and Senator Laura Richardson (D-Long Beach) as Majority Leader.

Federal Indictment in the Capitol – The Capitol has also been shaken by the recent federal indictment of Dana Williamson, Governor Newsom's former Chief of Staff (2022-24). The indictment alleges a bribery and influence-peddling scheme in which Williamson and others are accused of facilitating payments from clients seeking favorable treatment from state officials. Two key figures—Greg Campbell, lobbyist and former Chief of Staff to Assembly Speaker John Perez, and Sean McCluskie, former Chief of Staff to then-Attorney General Xavier Becerra—have entered plea agreements, and the charging documents reference an unnamed cooperating co-conspirator, strongly suggesting active assistance to prosecutors as the investigation widens.

Federal actions like this tend to trigger a predictable institutional response inside the Capitol: expect a flurry of ethics-related legislation, slower timelines on sensitive bills, heightened scrutiny of political and lobbying relationships, and a meaningful advantage for long-established, highly trusted representatives who can operate effectively in a more cautious and process-oriented environment. This story will continue throughout the year.

"Outcome Review" Legislative Tool – Finally, Speaker Robert Rivas announced a first-of-its-kind legislative oversight tool that empowers Assembly members to assess, review and improve implementation of enacted laws that they've authored or championed — aiming for elevated community engagement, better outcomes, and lasting benefits for Californians. Set to launch in January, this new approach underscores the Speaker's ongoing commitment to strong accountability and transparency in government.

Budget Update

Senate Budget Informational Hearing – The Senate Budget and Fiscal Review Committee's Subcommittee No. 3 on Health & Human Services held an informational hearing on November 14 titled *"Forecasts and Estimates: Crafting the Budget for California's Health Programs."* The hearing was chaired by Senator Dr. Akilah Weber Pierson, who was the only subcommittee member in attendance. Discussion centered on how the Department of Health Care Services (DHCS), Department of Public Health, and Department of Finance develop estimates for major health programs, operations, and related expenditures. This topic has long been a point of concern for the Chair, and she pressed the administration on how key assumptions and determinations are made in shaping the state's health care delivery system. It remains unclear whether the testimony offered fully satisfied her concerns. The background brief can be found HERE.

Legislative Analyst's Office (LAO) Budget Reports – In November, the nonpartisan LAO released two important reports: *2026-27 Budget: California's Fiscal Outlook* and the accompanying *2026-27 Budget: Medi-Cal Fiscal Outlook*. While the State has seen revenue continue to improve, the overall budget remains grim. The LAO recommends that the legislature address the budget issue through spending reductions and revenue increases.

The reports highlight the following anticipated healthcare impacts:

- $18 billion projected overall budget shortfall for 2026-27 – $5 billion more than June estimates
- $35 billion annual structural deficit in 2027-28 – revenue growth is outpaced by spending
- $6.7 billion increase in Medi-Cal costs – from $44.9 billion (2025-26) to $51.6 billion (2029-30)
    - $1.3 billion impacts of H.R. 1 across Medi-Cal and CalFresh – provider tax impacts not included
    - $3.3 billion increased spending (over multi-years) due to H.R. 1's impact to the MCO Tax/Prop 35
    - 3.3% (500,000) decrease in family caseloads since 2025-26, which is expected to continue
    - The largest Medi-Cal cost drivers are provider tax restrictions and the state's share of cost increasing for limited-scope coverage of beneficiaries with Unsatisfactory Immigration Status (UIS)
    - Other spending increases include provider rates, utilization of services, and senior caseloads

The overall budget outlook can be found HERE, and the specific Medi-Cal outlook can be found HERE.

PACE Moratorium – On November 17, DHCS issued a Policy Letter announcing a pause on accepting all new PACE applications, including applications for new PACE organizations and service area expansions by existing programs. The pause took effect on November 20, 2025, and will remain in place for a minimum of two years. Applications already in process will continue to move forward and are not affected. DHCS stated that the pause is necessary to ensure adequate state capacity to oversee the PACE program and to manage the program's current rate of growth. CalPACE is working on possible funding solutions to propose to DHCS to shorten this moratorium.

Initiative & Proposition Update

Election Rigging Response Act (Proposition 50) – Proposition 50, which appeared on the November 4, 2025, special election ballot, was approved by voters with 7,436,465 votes in favor (64.4%) and 4,110,198 votes against (35.6%). With its passage, the new Legislature-drawn congressional map will govern U.S. House elections in 2026, 2028, and 2030, after which redistricting authority will revert to the Citizens Redistricting Commission following the 2030 Census.

Following certification of the results, multiple lawsuits were filed—primarily by Republican-aligned plaintiffs—challenging the constitutionality of the measure while alleging partisan gerrymandering. These cases are now pending in state and federal courts, with early motions focused on whether implementation of the new maps should be stayed while litigation proceeds.

"2026 Billionaires' Tax Act" – This proposed initiative would impose a one-time 5% tax on the net worth of individuals with more than $1 billion, generating an estimated $100 billion to help address anticipated Medi-Cal shortfalls, support safety-net health care providers, and provide additional funding for K-12 education. The initiative was filed on October 22, 2025, requesting preparation of the official Title and Summary. The public comment period closed on November 21, and the Attorney General now has up to 65 days (until January 25, 2026) to issue the Title and Summary, after which signature gathering may begin. The measure is being spearheaded by SEIU–United Healthcare Workers West (SEIU-UHW) in partnership with St. John's Community Health in Los Angeles.

2025–26 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
SB 483 Stern	**Mental Health Diversion:** Would require that a court be satisfied that a recommended mental health treatment program is consistent with the underlying purpose of mental health diversion and meets the specialized treatment needs of the defendant. ***Potential CalOptima Health Impact*:** Increased oversight of behavioral health treatment for members.	**07/16/2025** Passed Assembly Public Safety Committee; referred to Assembly Appropriations Committee **06/04/2025** Passed Senate floor	CalOptima Health: Watch
SB 626 Smallwood-Cuevas	**Maternal Mental Health Screenings and Treatment:** Would require a licensed health care practitioner who provides perinatal care for a patient to screen, diagnose and treat the patient for a maternal mental health condition. ***Potential CalOptima Health Impact:*** Increased access to behavioral health services for eligible members.	**07/15/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **06/02/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose
SB 812 Allen	**Qualified Youth Drop-In Center Health Care Coverage:** Would require a health plan to provide coverage for mental health and substance use disorders at a qualified youth drop-in center, defined as a center providing behavioral or primary health and wellness services to youth 12 to 25 years of age with the capacity to provide services before and after school hours and that has been designated by or embedded with a local educational agency or institution of higher education. ***Potential CalOptima Health Impact*:** Increased access to behavioral health services for CalOptima Health Medi-Cal youth members.	**07/16/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/28/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Concerns
AB 37 Elhawary	**Behavioral Health Workforce:** Would require the California Workforce Development Board to study how to expand the workforce of mental health service providers providing services to homeless persons. ***Potential CalOptima Health Impact*:** Increased access to behavioral health services for members experiencing homelessness.	**03/13/2025** Referred to Assembly Labor and Employment Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 348 Krell	**Full-Service Partnership:** Establishes presumptive eligibility for Full-Service Partnership programs contingent upon meeting criteria and receiving recommendation for enrollment by a licensed behavioral health clinician. ***Potential CalOptima Health Impact*:** Increased continuity of care for members with serious mental illness.	**10/13/2025** Signed into law	CalOptima Health: Watch
AB 384 Connolly	**Inpatient Prior Admission Authorization:** Would prohibit a health plan from requiring prior authorization for admission to medically necessary 24-hour care in inpatient settings, including general acute care hospitals and psychiatric hospitals, for mental health and substance use disorders (SUDs) as well as for any medically necessary services provided to a beneficiary while admitted for that care. ***Potential CalOptima Health Impact*:** Modified utilization management (UM) procedures for covered Medi-Cal benefits.	**04/22/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
AB 423 Davies	**Disclosures for Alcoholism, Drug Abuse Recovery or Treatment Programs and Facilities:** Would mandate a business-operated recovery residence to register its location with the California Department of Health Care Services (DHCS). ***Potential CalOptima Health Impact*:** Increased oversight for members who have received SUD treatment.	**02/18/2025** Referred to Assembly Health Committee	CalOptima Health: Watch
AB 618 Krell	**Behavioral Health Data Sharing:** Would require each Medi-Cal managed care plan (MCP), county specialty mental health plan (MHP) and Drug Medi-Cal program to electronically share data for its members to support coordination of behavioral health services. Would also require DHCS to determine minimum data elements and the frequency and format of data sharing through a stakeholder process and guidance, with final guidance to be published by January 1, 2027. ***Potential CalOptima Health Impact*:** Increased coordination between Medi-Cal delivery systems regarding behavioral health services.	**07/07/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/03/2025** Passed Assembly floor	**05/07/2025** CalOptima Health: SUPPORT LHPC: Sponsor

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 877 Dixon	**Nonmedical SUD Treatment:** Would require DHCS and the California Department of Managed Health Care (DMHC) to send a letter to the chief financial officer of every health plan (including a Medi-Cal MCP) that provides SUD coverage in residential facilities. The letter must inform the plan that SUD treatment in licensed or unlicensed facilities is almost exclusively nonmedical, with rare exceptions, including for billing purposes. These provisions would be repealed on January 1, 2027. ***Potential CalOptima Health Impact*:** Enhanced transparency and clarity around nonmedical treatment provided for SUDs.	**03/03/2025** Referred to Assembly Health Committee	CalOptima Health: Watch
AB 951 Ta	**Autism Diagnosis:** Prohibits a health plan from requiring an enrollee previously diagnosed with pervasive developmental disorder or autism to receive a diagnosis to maintain coverage for behavioral health treatment for their condition. ***Potential CalOptima Health Impact*:** Increased access to care for specific behavioral health treatments.	**07/30/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Budget			
H.R. 1 Arrington (TX)	**One Big Beautiful Bill Act:** Makes substantial changes to Medicaid program funding and policies, including but not limited to the following: • Work, community service and/or education requirement of 80 hours per month for able-bodied adults without dependents (with exceptions for pregnant women, foster youth, medically frail, caregivers and others), effective December 31, 2026, or no later than December 31, 2028 • Increased frequency of eligibility redeterminations for Medicaid Expansion (MCE) enrollees from annually to every six months, effective December 31, 2026 • Emergency Medicaid services provided to all undocumented beneficiaries subject to the traditional Federal Medical Assistance Percentage (FMAP) — 50% in California — regardless of the FMAP for which those would otherwise be eligible, effective October 1, 2026 Cost-sharing for MCE enrollees with incomes of 100–138% Federal Poverty Level (FPL), not to exceed $35 per service and 5% of total income, and not to be applied to primary, prenatal, pediatric, or emergency care, effective October 1, 2028 • Prohibition on any new or increased provider taxes, effective immediately • Significant restrictions on current Managed Care Organization (MCO) taxes, which could effectively repeal California's MCO tax that was recently made permanent by Proposition 35 (2024), with a potential winddown period of up to three fiscal years (FYs) ***Potential CalOptima Health Impact*:** Reduced funding to CalOptima Health and contracted providers; decreased number of members; increased administrative costs; implementation of co-pay systems; increased financial and administrative burdens for some existing members; decreased health care utilization by some existing members; reduced benefits for some existing members. A separate overview is also enclosed.	**07/04/2025** Signed into law	**05/20/2025** CalOptima Health: OPPOSE

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 101 Wiener **AB 102** Gabriel	**Budget Act of 2025:** Makes appropriations for the government of the State of California for FY 2025–26. Total spending is $321 billion, of which $228.4 billion is from the General Fund. ***Potential CalOptima Health Impact:*** An overview of the FY 2025–26 Enacted State Budget is enclosed.	**06/30/2025** Signed into law	CalOptima Health: Watch
AB 100 Gabriel	**Budget Acts of 2023 and 2024:** Increases Medi-Cal's current FY 2024–25 General Fund appropriation by $2.8 billion and federal funds appropriation by $8.25 billion in order to solve a deficiency in the Medi-Cal budget. ***Potential CalOptima Health Impact:*** Continued funding for current Medi-Cal rates and initiatives through June 30, 2025.	**04/14/2025** Signed into law	CalOptima Health: Watch
AB 116 Committee on Budget	**Health Omnibus Trailer Bill:** Consolidates and enacts certain budget trailer bill language containing policy changes needed to implement health-related budget expenditures. Provisions related to the Medi-Cal program include but are not limited to the following: • Enrollment freeze for undocumented individuals 19 years or older, effective no sooner than January 1, 2026, with exceptions for pregnant individuals • Implementation of $30 monthly premiums for undocumented individuals ages 19-59, effective no sooner than July 1, 2027 • Reinstatement of the asset limit at $130,000 for individuals, adding $65,000 for each additional household member, capping at 10 members, effective January 1, 2026 • Enacts PACE provider sanctions, effective immediately ***Potential CalOptima Health Impact:*** An overview of the FY 2025–26 Enacted State Budget is enclosed.	**06/30/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
California Advancing and Innovating Medi-Cal (CalAIM)			
SB 324 Menjivar	**Enhanced Care Management (ECM) and Community Supports Contracting:** Would require a Medi-Cal MCP to give preference to contracting with community providers that demonstrate capability of providing access and meeting quality requirements when covering the ECM benefit and/or Community Supports. In addition, would require DHCS to develop standardized templates to be used by MCPs. Would also require DHCS to develop guidance to allow community providers to subcontract with other community providers. ***Potential CalOptima Health Impact*:** Increased collaboration with community providers and standardized contracts.	**07/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/27/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Watch LHPC: Oppose
AB 543 Gonzalez	**Street Medicine:** Authorizes a Medi-Cal MCP to elect to offer Medi-Cal covered services through a street medicine provider. MCPs that elect to do so would be required to allow a Medi-Cal beneficiary who is experiencing homelessness to receive those services directly from a contracted street medicine provider, regardless of the beneficiary's network assignment. Additionally, requires the MCP to allow a contracted street medicine provider enrolled in Medi-Cal to directly refer the beneficiary for covered services within the appropriate network and share that information with the relevant county for inclusion in CalSAWS. ***Potential CalOptima Health Impact*:** Continued access to street medicine services for members experiencing homelessness.	**10/06/2025** Signed into law	CalOptima Health: Watch CAHP: Watch
Covered Benefits			
SB 40 Wiener	**Insulin Coverage:** Prohibits a health plan, effective January 1, 2026 (or a policy offered in the individual or small group market, effective January 1, 2027), from imposing a copayment or other cost sharing of more than $35 for a 30-day supply of an insulin prescription drug or imposing a deductible, coinsurance, or any other cost sharing on an insulin prescription drug. Additionally, requires a health plan to cover all types of insulin without step therapy on and after January 1, 2026. ***Potential CalOptima Health Impact:*** Decreased out-of-pocket costs for future members enrolled in Covered California line of business; new UM procedures.	**10/13/2025** Signed into law	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 62 Menjivar **AB 224** Bonta	**Essential Health Benefits (EHBs):** Expresses the intent of the Legislature to review California's EHB benchmark plan and establish a new benchmark plan for the 2027 plan year. Additionally, upon approval from the United States Department of Health and Human Services and by January 1, 2027, requires the new benchmark plan include certain additional benefits, including coverage for fertility services, hearing aids and exams, and durable medical equipment. ***Potential CalOptima Health Impact:*** New covered benefits for future members enrolled in Covered California line of business.	**10/13/2025** SB 62 signed into law **10/13/2025** AB 224 signed into law	CalOptima Health: Watch CAHP: Concerns
SB 535 Richardson **AB 575** Arambula	**Obesity Care Access Act:** Would require an individual or group health care plan that provides coverage for outpatient prescription drug benefits to cover at least one specified anti-obesity medication and bariatric surgery for the treatment of obesity. ***Potential CalOptima Health Impact:*** Expanded covered benefits for future members enrolled in Covered California line of business.	**07/15/2025** SB 535 passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/28/2025** SB 535 passed Senate floor **02/24/2025** AB 575 referred to Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 242 Boerner	**Genetic Disease Screening:** Would expand statewide newborn screenings to include Duchenne muscular dystrophy by January 1, 2027. ***Potential CalOptima Health Impact:*** Expanded covered benefits for members.	**04/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 298 Bonta	**Cost-Sharing Under Age 21:** Effective January 1, 2026, would prohibit a health plan from imposing a deductible, coinsurance, copayment, or other cost-sharing requirement for in-network health care services provided to an individual under 21 years of age, with certain exceptions for high deductible health plans that are combined with a health savings account. ***Potential CalOptima Health Impact:*** Increased costs for CalOptima Health; decreased costs for future members enrolled in Covered California line of business under 21 years of age.	**02/10/2025** Referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 350 Bonta	**Fluoride Treatments:** Would require a health plan to provide coverage for fluoride varnish in the primary care setting for children under 21 years of age by January 1, 2026. ***Potential CalOptima Health Impact:*** New covered benefit for pediatric members.	**08/29/2025** Passed Senate Appropriations Committee; referred to Senate floor **07/02/2025** Passed Senate Health Committee **06/02/2025** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 432 Bauer-Kahan	**Menopause:** Would have required a health plan that covers outpatient prescription drugs to provide coverage for evaluation and treatment options for symptoms of perimenopause and menopause. Would also have required a health plan to annually provide clinical care recommendations for hormone therapy to all contracted primary care providers who treat individuals with perimenopause and menopause. ***Potential CalOptima Health Impact:*** New covered benefits for members; increased communications to providers.	**10/13/2025** Vetoed	CalOptima Health: Watch CAHP: Oppose
AB 636 Ortega	**Diapers:** Would add diapers as a covered Medi-Cal benefit for the following individuals, contingent upon 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 members.	**04/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Eligibility and Enrollment			
AB 315 Bonta	**Home and Community-Based Alternatives (HCBA) Waiver:** Would remove the cap on the number of HCBA Waiver slots and instead require DHCS to enroll all eligible individuals who apply for HCBA Waiver services. By March 1, 2026, would require DHCS to seek any necessary waiver amendments to ensure there is sufficient capacity to enroll all individuals currently on a waiting list. Would also require DHCS by March 1, 2026, to submit a rate study to the Legislature addressing the sustainability, quality and transparency of rates for the HCBA Waiver. ***Potential CalOptima Health Impact*:** Expanded member access to HCBA Waiver services.	**03/25/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 974 Patterson	**Managed Care Enrollment Exemption:** Would exempt any dual-eligible and non-dual-eligible beneficiaries who receive services from a regional center and who use the Medi-Cal fee-for-service delivery system as a secondary form of health care coverage from mandatory enrollment in a Medi-Cal MCP. ***Potential CalOptima Health Impact:*** Decreased number of members.	**04/22/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 1012 Essayli	**Unsatisfactory Immigration Status:** Would make an individual who does not have satisfactory immigrant status ineligible for Medi-Cal benefits. In addition, would transfer funds previously appropriated for such eligibility to a newly created Serving our Seniors Fund to restore and maintain payments for Medicare Part B premiums for eligible individuals. ***Potential CalOptima Health Impact:*** Decreased number of members.	**02/21/2025** Introduced	CalOptima Health: Watch
AB 1161 Harabedian	**State of Emergency Continuous Eligibility:** Would require DHCS and the California Department of Social Services to provide continuous eligibility for its applicable programs (including Medi-Cal and CalFresh) to all beneficiaries within a geographic region who have been affected by a state of emergency or a health emergency. ***Potential CalOptima Health Impact*:** Extended Medi-Cal eligibility for certain members.	**04/29/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **04/08/2025** Passed Assembly Human Services Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Operations and Administration			
SB 278 Cabaldon	**Health Data HIV Test Results:** Authorizes disclosures of HIV test results that identify or include identifying characteristics of a Medi-Cal beneficiary without written authorization of the member or their representative to the MCP for quality improvement efforts such as value-based payment and incentive programs. ***Potential CalOptima Health Impact:*** Increased quality oversight of HIV program development.	**10/13/2025** Signed into law	CalOptima Health: Watch
SB 497 Wiener	**Legally Protected Health Care Activity:** Prohibits a health care provider, health plan, or contractor from releasing medical information related to a person seeking or obtaining gender-affirming health care or mental health care in response to a criminal or civil action. Also prohibits these entities from cooperating with or providing medical information to an individual, agency, or department from another state or to a federal law enforcement agency or in response to a foreign subpoena. ***Potential CalOptima Health Impact:*** Increased protection of medical information related to gender-affirming care; increased staff training regarding disclosure processes.	**10/13/2025** Signed into law	CalOptima Health: Watch
SB 530 Richardson	**Medi-Cal Time and Distance Standards:** Extends current Medi-Cal time and distance standards until January 1, 2029. In addition, requires a Medi-Cal MCP to ensure that each subcontractor network complies with certain appointment time standards and incorporate into reporting to DHCS, unless already required to do so. Additionally, the use of telehealth providers to meet time or distance standards does not absolve the MCP of responsibility to provide a beneficiary with access, including transportation, to in-person services if the beneficiary prefers. ***Potential CalOptima Health Impact:*** Increased oversight of contracted providers; increased reporting to DHCS.	**10/06/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 660 Menjivar	**California Health and Human Services Data Exchange Framework (DxF):** Requires the Center for Data Insights and Innovation within California Health and Human Services Agency (CalHHS) to absorb all functions related to the DxF initiative, including the data sharing agreement and policies and procedures, by January 1, 2026. Additionally, expands DxF to include social services information. ***Potential CalOptima Health Impact:*** Increased care coordination with social service providers.	**10/03/2025** Signed into law	CalOptima Health: Watch
AB 45 Bauer-Kahan	**Reproductive Data Privacy:** Prohibits the collection, use, disclosure, sale, sharing, or retention of the information of a person who is physically located at, or within a precise geolocation of, a family planning center, except any collection or use necessary to perform services or provide goods that have been requested. Also authorizes an aggrieved person to institute and prosecute a civil action against any person or organization in violation of these provisions. ***Potential CalOptima Health Impact:*** Increased safeguards regarding reproductive health information.	**09/26/2025** Signed into law	CalOptima Health: Watch
AB 257 Flora	**Specialty Telehealth Network Demonstration:** Would require the establishment of a demonstration project or grant program for a telehealth and other virtual services specialty care network designed to serve patients of safety-net providers. ***Potential CalOptima Health Impact:*** Expanded member access to telehealth specialists.	**03/25/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
AB 316 Krell	**Artificial Intelligence Defenses:** Prohibits a defendant that developed or used artificial intelligence from asserting a defense that artificial intelligence autonomously caused the alleged harm to the plaintiff. ***Potential CalOptima Health Impact:*** Increased liability related to UM procedures.	**10/13/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 403 Ortega	**Medi-Cal Community Health Service Workers:** Would require DHCS to annually review the Community Health Worker (CHW) benefit and present an analysis to the Legislature beginning July 1, 2027. The analyses would include an assessment of Medi-Cal MCP outreach and education efforts, CHW utilization and services, demographic disaggregation of the CHWs and beneficiaries receiving services, and fee-for-service reimbursement data. ***Potential CalOptima Health Impact:*** New reporting requirements to DHCS.	**03/25/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 577 Wilson	**Prescription Drug Antisteering:** Would prohibit a health plan or pharmacy benefit manager (PBM) from engaging in specified steering practices, including requiring an enrollee to use a retail pharmacy for dispensing prescription oral medications and imposing any requirements, conditions or exclusions that discriminate against a physician in connection with dispensing prescription oral medications. Additionally, would require a health care provider, physician's office, clinic or infusion center to obtain consent from an enrollee and disclose a good faith estimate of the applicable cost-sharing amount before supplying or administering an injected or infused medication. ***Potential CalOptima Health Impact:*** Increased oversight of contracted PBM and referral processes.	**04/29/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 688 Gonzalez	**Telehealth for All Act of 2025:** Beginning in 2028 and every two years thereafter, requires DHCS to use Medi-Cal data and other data sources to produce analyses in a publicly available Medi-Cal telehealth utilization report. ***Potential CalOptima Health Impact:*** New reporting requirements to DHCS.	**10/07/2025** Signed into law	CalOptima Health: Watch
AB 980 Arambula	**Health Plan Duty of Care:** As it pertains to the required "duty of ordinary care" by a health plan, would define "medically necessary health care service" to mean legally prescribed medical care that is reasonable and comports with the medical community standard. ***Potential CalOptima Health Impact:*** Modified UM procedures.	**04/22/2025** Re-referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Older Adult Services			
SB 242 Blakespear	**Medicare Supplemental Coverage Open Enrollment Periods:** Would make Medicare supplemental benefit plans available to qualified applicants with end stage renal disease under the age of 64 years. Would also create an annual open enrollment period for Medicare supplemental benefit plans and prohibit such plans from denying an application or adjusting premium pricing due to a preexisting condition. Additionally, would authorize premium rates offered to applicants during the open enrollment period to vary based on the applicant's age at the time of issue, but would prohibit premiums from varying based on age after the contract is issued. ***Potential CalOptima Health Impact:*** Expanded Medicare coverage options for dual-eligible members.	**04/30/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
SB 412 Limón	**Home Care Aides:** Requires a home care organization to ensure that a home care aide completes training related to the special care needs of clients with dementia prior to providing care and annually thereafter. ***Potential CalOptima Health Impact:*** New training requirements for PACE staff.	**10/06/2025** Signed into law	CalOptima Health: Watch
Providers			
SB 32 Weber Pierson	**Timely Access to Care:** Would require DHCS, DMHC and the California Department of Insurance to consult stakeholders for the development and adoption of geographic accessibility standards of perinatal units to ensure timely access for enrollees by July 1, 2027. ***Potential CalOptima Health Impact:*** Additional timely access standards; increased contracting with perinatal units.	**07/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **06/02/2025** Passed Senate floor	CalOptima Health: Watch LHPC: Oppose
SB 250 Ochoa Bogh	**Medi-Cal Provider Directory — Skilled Nursing Facilities:** Requires an annually updated provider directory issued by a Medi-Cal MCP to include skilled nursing facilities as a searchable provider type. ***Potential CalOptima Health Impact:*** Modifications to CalOptima Health's online provider directory.	**10/03/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 306 Becker	**Prior Authorization Exemption:** No later than January 1, 2028, requires health plans — except Medi-Cal MCPs — to eliminate prior authorization for the most frequently approved health care services, except in cases of fraudulent provider activity or clinically inappropriate care. ***Potential CalOptima Health Impact:*** In future Covered California line of business, implementation of new UM procedures to assess prior authorization approval rates; decreased number of prior authorizations; decreased care coordination for members.	**10/06/2025** Signed into law	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
SB 504 Laird	**HIV Reporting:** Authorizes a health care provider for a patient with an HIV infection that has already been reported to a local health officer to communicate with a local health officer or the California Department of Public Health (CDPH) to obtain public health recommendations on care and treatment or to refer the patient to services provided by CDPH. ***Potential CalOptima Health Impact:*** Increased coordination of care for HIV-positive members.	**10/13/2025** Signed into law	CalOptima Health: Watch
AB 29 Arambula	**Adverse Childhood Experiences (ACEs) Screening Providers:** Would require DHCS to include community-based organizations, local health jurisdictions and doulas as qualified providers for ACEs trauma screenings and require clinical or other appropriate referrals as a condition of Medi-Cal payment for conducting such screenings. ***Potential CalOptima Health Impact:*** Increased access to care for pediatric members with ACEs.	**04/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 50 Bonta	**Over-the-Counter Contraceptives:** Allows pharmacists to provide over-the-counter hormonal contraceptives without following certain procedures and protocols, such as requiring patients to complete a self-screening tool. As such, these requirements are limited to prescription-only hormonal contraceptives. ***Potential CalOptima Health Impact:*** Increased member access to hormonal contraceptives.	**09/26/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 55 Bonta	**Alternative Birth Centers Licensing:** Removes the requirement for alternative birth centers to provide comprehensive perinatal services as a condition of CDPH licensing and Medi-Cal reimbursement. ***Potential CalOptima Health Impact:*** Decreased member access to comprehensive perinatal services; reduced operating requirements for alternative birth centers.	**10/11/2025** Signed into law	CalOptima Health: Watch LHPC: Support
AB 220 Jackson	**Medi-Cal Subacute Care Authorization:** Would require a provider seeking prior authorization for pediatric subacute or adult subacute care services under the Medi-Cal program to submit a specified form. Additionally, would prohibit a Medi-Cal MCP from developing or using its own criteria for medical necessity and from requiring a subsequent treatment authorization request upon a patient's return from a bed hold for acute hospitalization. ***Potential CalOptima Health Impact:*** Modified UM procedures and forms.	**09/04/2025** Passed Senate floor; referred to Assembly for concurrence in amendments **05/29/2025** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 280 Aguiar-Curry	**Provider Directory Accuracy:** Would require health plans — except Medi-Cal MCPs — to maintain accurate provider directories, starting with minimum 60% accuracy by July 1, 2026, and increasing to 95% by July 1, 2029, or otherwise receive administrative penalties. If a patient relies on inaccurate directory information, would require the provider to be reimbursed at the out-of-network rate without the patient incurring charges beyond in-network cost-sharing amounts. Would also allow DMHC to update standardized formats to collect directory information as well as establish methodologies to ensure accuracy, such as use of a central utility, by January 1, 2026. Additionally, would require a health plan to provide information about in-network providers to enrollees upon request, including whether the provider is accepting new patients at the time, and would limit the cost-sharing amounts an enrollee is required to pay for services from those providers under specified circumstances. Would also require that, within 30 days of receiving a request from a health plan, a provider must confirm that its information is current and accurate or update the required information. ***Potential CalOptima Health Impact:*** In future Covered California line of business, increased oversight of provider directory; increased coordination with contracted providers; increased penalty payments to DMHC.	**07/09/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/02/2025** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose
AB 375 Nguyen	**Qualified Autism Service Paraprofessional:** Would expand the definition of "health care provider" to also include a qualified autism service paraprofessional. ***Potential CalOptima Health Impact:*** Increased access to autism services for eligible members; additional provider contracting and credentialing.	**04/08/2025** Passed Assembly Business and Professions Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 416 Krell	**Involuntary Commitment:** Authorizes a person to be taken into custody by an emergency physician under the Lanterman-Petris-Short Act and exempts the emergency physician from criminal and civil liability. ***Potential CalOptima Health Impact:*** New legal standards for certain CalOptima Health providers.	**10/13/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 510 Addis	**Utilization Review Peer-to-Peer Review:** Would allow a provider to request review of a decision to delay, deny or modify health services by another physician or peer health care professional matching the specialty of the service within two business days. In urgent cases, responses must match the urgency of the patient's condition. If these deadlines are not met, the authorization request would be automatically approved. ***Potential CalOptima Health Impact***: Expedited and modified UM, grievance and appeals procedures for covered Medi-Cal benefits; increased hiring of specialists to review grievances and appeals.	**04/22/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
AB 512 Harabedian	**Prior Authorization Timelines:** Would have shortened the timeline for prior or concurrent authorization requests to no more than 24 hours via electronic submission or 48 hours via non-electronic submission for *urgent* requests and three business days via electronic submission or five business days via non-electronic submission for *standard* requests, starting from plan receipt of the information reasonably necessary and requested by the plan to make the determination. ***Potential CalOptima Health Impact***: Expedited and modified UM procedures for covered Medi-Cal benefits.	**10/06/2025** Vetoed	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
AB 517 Krell	**Wheelchair Prior Authorization:** Would prohibit a Medi-Cal MCP from requiring prior authorization for the repair of a Complex Rehabilitation Technology (CRT)-powered wheelchair, if the cost of repair does not exceed $1,250. Would also no longer require a prescription or documentation of medical necessity, if the wheelchair has already been approved for use by the patient. Additionally, would require supplier documentation of the repair. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**04/08/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 539 Schiavo	**One-Year Prior Authorization Approval:** Would require a prior authorization for a health care service to remain valid for a period of at least one year, or throughout the course of prescribed treatment if less than one year, from the date of approval. ***Potential CalOptima Health Impact:*** Modified UM procedures for covered Medi-Cal benefits; decreased number of prior authorizations; increased costs.	**05/12/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
AB 787 Papan	**Provider Directory Disclosures:** Would require a health plan to include in its provider directory a statement advising an enrollee to contact the plan for assistance in finding an in-network provider. Would also require the plan to respond within one business day if contacted for such assistance and to provide a list of in-network providers confirmed to be accepting new patients within two business days for urgent requests and five business days for nonurgent requests. Medi-Cal MCPs would not be required to distribute a printed provider directory. ***Potential CalOptima Health Impact:*** Expanded customer service support and staff training; technical changes to CalOptima Health's provider directory.	**06/18/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/05/2025** Passed Assembly floor	CalOptima Health: Watch
AB 1041 Bennett	**Provider Credentialing:** Requires a health plan — except a Medi-Cal MCP — to credential a provider within 90 days from the receipt of a completed application, or otherwise conditionally approve the credential. A plan is required to notify the provider whether the application is complete within 10 days of receipt. Additionally, requires a health plan to subscribe to and use the Council for Affordable Quality Healthcare credentialing form on and after January 1, 2028. ***Potential CalOptima Health Impact:*** Expedited and modified credentialing procedures for interested providers in future Covered California line of business.	**10/11/2025** Signed into law	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose Unless Amended

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Rates & Financing			
SB 339 Cabaldon	**Medi-Cal Laboratory Rates:** Would require Medi-Cal reimbursement rates for clinical laboratory or laboratory services to *equal* the lowest of the following metrics: 1. the amount billed; 2. the charge to the general public; 3. 100% of the lowest maximum allowance established by Medicare; or 4. a reimbursement rate based on an average of the lowest amount that other payers and state Medicaid programs are paying. For any such services related to the diagnosis and treatment of sexually transmitted infections on or after July 1, 2027, the Medi-Cal reimbursement rates shall not consider the rates described in clause (4) listed above. ***Potential CalOptima Health Impact*:** Increased payments to contracted clinical laboratories.	**04/29/2025** Passed Senate Judiciary Committee; referred to Senate Appropriations Committee **04/23/2025** Passed Senate Health Committee	CalOptima Health: Watch

Information in this document is subject to change as bills proceed through the legislative process.

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

Last Updated: November 21, 2025

2025 Federal Legislative Dates

January 3	119th Congress, 1st Session convenes
July 25–September 1	Summer recess for House
August 2–September 1	Summer recess for Senate
December 19	1st session adjourns

Source: Floor Calendars, United States Congress: https://www.congress.gov/calendars-and-schedules

2025 State Legislative Dates

January 6	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
February 21	Last day for legislation to be introduced
April 10–20	Spring recess
May 2	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house
May 9	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house
May 23	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house
June 2–6	Floor session only
June 6	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 18	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 18–August 17	Summer recess
August 29	Last day for fiscal committees to report bills in their second house to the Floor
September 2–12	Floor session only
September 5	Last day to amend bills on the Floor
September 12	Last day for each house to pass bills; interim recess begins upon adjournment
October 12	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2025 Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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About CalOptima Health

CalOptima Health is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to serve member health with excellence and dignity, respecting the value and needs of each person. We provide coverage through three major programs: Medi-Cal, OneCare (HMO D-SNP) and the Program of All-Inclusive Care for the Elderly (PACE).

H.R. 1: One Big Beautiful Bill Act

Fiscal Year 2025 Federal Budget Reconciliation

As signed into law on July 4, 2025

Please note that H.R. 1 includes several distinct implementation dates over the coming years, but there are no major immediate impacts to Medicaid beneficiaries until 2026.

In addition, most Medicaid provisions of H.R. 1 still require federal rulemaking by the U.S. Centers for Medicare and Medicaid Services (CMS) and subsequent state implementation by the California State Legislature and/or the California Department of Health Care Services (DHCS).

MEDICAID HIGHLIGHTS
Eligibility
Work, community service and/or education requirement of **80 hours per month** for able-bodied adults ages 19–64 (with exceptions for short-term hardship, parents with dependents under age 14, pregnant women, medically frail, caregivers and others), effective **December 31, 2026** (or no later than **December 31, 2028**, at the discretion of the U.S. Secretary of Health and Human Services [HHS])
Increased frequency of eligibility redeterminations for Medicaid Expansion (MCE) enrollees from annually to **every six months**, effective **December 31, 2026**
Financing
Prohibition on any new or increased provider taxes, effective **immediately**
Existing provider taxes (except those related to nursing or intermediate care facilities) would be gradually reduced from the current maximum **6.0%** hold harmless threshold to a new **3.5%** hold harmless threshold by **0.5% annually** from **October 1, 2027, through October 1, 2031**
Significant restrictions on current Managed Care Organization (MCO) taxes, which could effectively **repeal** California's MCO tax that was recently made permanent by Proposition 35 (2024), with a potential winddown period of up to **three fiscal years** at the discretion of the HHS Secretary
Cap on new state-directed payments (SDPs) at **100%** of the Medicare payment rate, effective **immediately**; gradually reduces existing SDPs to that cap by **10% annually**, starting **January 1, 2028**
Emergency Medicaid services provided to all undocumented beneficiaries would be subject to the traditional Federal Medical Assistance Percentage (FMAP) — **50%** in California — regardless of the FMAP for which those would otherwise be eligible, effective **October 1, 2026**
Access
Cost-sharing for MCE enrollees with incomes of **100–138%** Federal Poverty Level (FPL), not to exceed **$35** per service and **5.0%** of total income, and not to be applied to primary, prenatal, pediatric, behavioral or emergency care, effective **October 1, 2028**
Temporary **one-year** prohibition on all Medicaid funding to Planned Parenthood, effective **immediately**

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Fiscal Year 2025–26 Enacted State Budget

On May 14, Governor Gavin Newsom released a Fiscal Year (FY) 2025–26 Revised State Budget Proposal, known as the May Revision. On June 13, the State Senate and State Assembly both passed a counterproposal — Senate Bill (SB) 101 — as a placeholder budget to meet the June 15 constitutional deadline while negotiations with the governor on a final budget remained ongoing.

On June 24, Gov. Newsom and legislative leaders announced a final budget agreement. After both houses of the Legislature passed the agreed-upon revisions as Assembly Bill (AB) 102 on June 27, Gov. Newsom signed both SB 101 and AB 102 into law. Additionally, the Legislature passed and the governor signed the consolidated Health Trailer Bill (AB 116) containing policy changes needed to implement health-related budget expenditures. Together, these bills represent the FY 2025-26 Enacted State Budget.

MEDI-CAL HIGHLIGHTS
Unsatisfactory Immigration Status (UIS)-Member Impacts
Freeze on *new* enrollment of UIS individuals ages 19+ (except those who are pregnant or one-year postpartum), effective **January 1, 2026**, including a three-month grace/cure period for re-enrollment following payment of outstanding premium balances; *currently enrolled* individuals are not affected
Implementation of $30/month premiums for UIS individuals ages 19–59, effectively **July 1, 2027**
Elimination of dental coverage for UIS individuals ages 19+, effective **July 1, 2026**
Elimination of Prospective Payment System rates to Federally Qualified Health Centers for state-only-funded services provided to UIS individuals, effective **July 1, 2026**
All-Member Impacts
Reinstatement of asset limit at $130,000 for individuals (plus $65,000 for each additional household member) in non-Modified Adjusted Gross Income eligibility categories, effective **January 1, 2026**
Elimination of pharmacy coverage for GLP-1 agonists for weight loss; coverage for diabetes and on a case-by-case basis will continue, effective **January 1, 2026**
Elimination of pharmacy coverage of some over-the-counter drugs, including COVID-19 antigen tests, vitamins and certain antihistamines, such as dry eye products, effective **January 1, 2026**
Implementation of prior authorization for hospice services, effective **July 1, 2026**
Limitation on capitation payments to Program of All-Inclusive Care for the Elderly (PACE) organizations at the midpoint of the actuarial rate ranges, effective **January 1, 2027**
Elimination of the Workforce and Quality Incentive Program (WQIP) for skilled nursing facilities, effective **December 31, 2025**, with all close-out activities to be completed by January 1, 2027

State agencies, including the California Department of Health Care Services, will begin implementing the policies included in the enacted budget. Staff will continue to monitor these policies and provide updates regarding issues that have a significant CalOptima Health impact. In addition, the Legislature will continue to advance policy bills through the legislative process. Bills with funding allocated in the enacted budget are more likely to be passed and signed into law. The Legislature has until September 12 to pass legislation, and Gov. Newsom has until October 12 to either sign or veto that passed legislation.

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CalOptima Health Community Outreach Summary —November and December 2025

Background

CalOptima Health is committed to serving the community by sharing information with current and potential members, as well as strengthening relationships with community partners. To this end, our team attends community coalitions, collaborative meetings and advisory groups and supports our community partners' public activities. Participation includes providing Medi-Cal educational materials and, if criteria are met, financial support and/or CalOptima Health-branded items.

CalOptima Health's participation in public activities promotes:

- Member interaction/enrollment in a CalOptima Health program
- Community awareness of CalOptima Health
- Partnerships that increase positive visibility and relationships with community organizations

Community Outreach Highlight

The holiday season is a time of joy, gratitude, and giving, and CalOptima Health is proud to announce that we will host our first annual CalOptima Health Holiday Resource Fair and Toy Distribution Event on Saturday, December 13, from 9 a.m. to 1 p.m. at the CalOptima Health building in Orange.

Recognizing that the holidays can bring financial challenges to many families, this event is designed to bring comfort, celebration and meaningful support to our members and their children. Families will receive toys, food, and diapers (while supplies last), and enjoy festive activities that foster connection and community spirit.

As part of this effort, we are also hosting an employee toy drive to help ensure every child receives a special holiday gift. We are grateful to our staff for their generosity and support.

Additionally, we are proud to partner with community organizations to meet the broader needs of our members. Mobile units will be on-site to provide health screenings. The County of Orange Social Services Agency will assist with Medi-Cal and CalFresh enrollment, 211OC will connect members with community resources and OCTA will share information on their programs and services.

Together we are spreading holiday cheer and helping ensure that Orange County families have the resources, care and support they need to thrive this season.

Summary of Public Activities

As of November 6, CalOptima Health plans to participate in, organize or convene 66 public activities in November and December. There were 44 public activities in November, including 15 community/collaborative meetings, 25 community events, three community-based presentations and one Health Network Forum. In December, there will be 21 public activities, including 14 community/collaborative meetings, six community

events, one Community Connections Meeting and one Health Network Forum. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided two endorsements since the last reporting period (i.e., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must meet the requirements of CalOptima Health's Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for Letters of Support and Use of CalOptima Health's Name and Logo. For more information on policy requirements, please visit: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

1. Letter of support of Korean Community Services, Inc. (KCS)'s application to the Proposition 1 Bond Behavioral Health Continuum Infrastructure Program (BHCIP) Round 2: Unmet Needs funding.
2. Letter of support of Providence St. Joseph in Orange's application for Bond Behavioral Health Continuum Infrastructure Program (BHCIP) Round 2: Unmet Needs funding for the development of a 96-bed acute behavioral health hospital at 1204 West Palmyra Avenue, Orange, CA 92868, in Orange County's Second Supervisorial District.

For additional information or questions, contact CalOptima Health Executive Director Deanne Thompson at 714-954-2141 or deanne.thompson@caloptima.org.

CalOptima Health

Attachment to the December 4, 2025, CalOptima Health Outreach Summary

Community events hosted by CalOptima Health and community partners in November and December 2025:

November 2025

November 1, 9 a.m.–Noon, Senior Resource Fair, hosted by Assemblyman Avelino Valencia and Assemblywoman Sharon Quirk-Silva

Brookhurst Community Center, 2271 W. Crescent Ave., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 1, 1–6 p.m., Dia de Los Muertos Health Fair, hosted by the City of San Clemente

Max Berg Plaza Park, 1100 Calle Puente, San Clemente

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 4, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 5, 12:30–1:30 p.m., School Resource Fair, hosted by Sunny Hills High School

Sunny Hills High School, 1801 Lancer Way, Fullerton

- 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

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 6, 11 a.m.–1 p.m., CalFresh Enrollment Party, hosted by Santa Ana College

Santa Ana College, 1530 W. 17th St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

November 6, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 7, 8–9 a.m., CalOptima Health Medi-Cal Overview in Spanish

Lampson Elementary School, 13321 Lampson Ave., Garden Grove

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

November 7, 9 a.m.–Noon, Senior Health and Wellness Fair, hosted by the City of La Habra

Our Lady of Guadalupe Catholic Church, 900 W. La Habra Blvd., La Habra

- Registration fee: $50; included a resource table
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 7, 10 a.m.–Noon, VITAS Healthcare, hosted by VITAS Healthcare

VITAS Healthcare, 310 Commerce Ste. 200, Irvine

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 7, 6–8 p.m., Dia de Los Muertos Health Fair, hosted by Valadez Middle School Academy

Valadez Middle School Academy, 161 E. La Jolla St., Placentia

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 8, 9 a.m.–1:30 p.m., Golden Future Senior Expo, hosted by Golden Future Expos

Sheraton Park Hotel, 1855 S. Harbor Blvd., Anaheim

- Registration fee: $1,495; included a resource table
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 12, 9:30–10:30 a.m., CalOptima Health Medi-Cal Overview in Vietnamese

Midway City Community Center, 14900 Park Ln., Midway City

- 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

Anaheim Neighborhood

- 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 13, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 14, 8 a.m.–2 p.m., Women's Health Summit, hosted by UC Irvine

Bren Event Center, 100 Mesa Rd., Irvine

- Sponsorship fee: $1,000; included two tickets, name and logo recognition in program, resource table, social media exposure and recognition from the stage.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public

November 14, 3–4 p.m., CalOptima Health Medi-Cal Overview in English

Legacy Square Apartments, 301 E. Santa Ana Blvd., Santa Ana

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

November 15, 9 a.m.–Noon, Family Health Fair, hosted by Melinda Hoag Smith Center for Healthy Living

Melinda Hoag Smith Center for Healthy Living, 307 Placentia Ave., Newport Beach

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 15, 9 a.m.–Noon, NAMI Walks Orange County, hosted by NAMI Orange County

Angel Stadium, 2000 E. Gene Autry Way, Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 15, 8 a.m.–Noon, Community Expo and Forum, hosted by March of Dimes

Newport Civic Center, 100 Civic Center Dr., Newport Beach

- Sponsorship fee: $1,500; included a resource table, logo and link on event website, digital program and select signage.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 18, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 19, 11 a.m.–2 p.m., Homeless and Hunger Awareness Week, hosted by Golden West College

Golden West College, 15744 Goldenwest St., Huntington Beach

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 19, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 20, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 21, 10 a.m.–2 p.m., Drive-Thru Free Food Distribution, hosted by County of Orange Supervisor Janet Ngueyn in partnership with CalOptima Health

Mile Square Park, 16801 Euclid St., Fountain Valley

- At least two staff members attended (in person)
- Health/Resource Fair, open to the public

November 22, 9 a.m.–1 p.m., Thanksgiving Food Distribution and Open House, hosted by CalOptima Health

CalOptima Health, 505 City Parkway W., Orange

- At least 20 staff members attended (in person)
- Health/Resource Fair, open to the public

November 22, 11 a.m.–2 p.m., Caregiver Resource Fair, hosted by Congressman Lou Correa

Fullerton Community Center, 340 W. Commonwealth Ave., Fullerton

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 25, 10 a.m.–2 p.m., AccessCal Fall Resource Fair, hosted by Access California Services

Access California Services, 300 W. Carl Karcher Way, Anaheim

- Sponsorship fee: $5,000; included a resource table
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 27, 7:30 a.m.–Noon, YMCA Gives Thanks, hosted by YMCA

TBD

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation Exhibitor/Attendee

- Sponsorship fee: $10,000; included meals for community residents, logo placement on signage, press releases, volunteer event shirts and post-event recognition.
- Health/Resource Fair, open to the public

December 2025

December 2, 9–10:30 a.m., CalOptima Health Community Connections Meeting, hosted by CalOptima Health

CalOptima Health, 505 City Parkway W., Orange

- At least six staff members attended (in person)
- Steering committee meeting, open to collaborative members

December 6, 9 a.m.–12:30 p.m., Holiday Resource Fair, hosted by TGR Learning Lab

TGR Learning Lab, 1 Tiger Woods Way, Anaheim

- At least one staff member will attend (in person)
- Health/Resource Fair, open to the public

December 6, 9 a.m.–1 p.m., 2nd Annual Holiday Resource Fair and Toy Distribution Event, hosted by Congressman Lou Correa in partnership with CalOptima Health

Magnolia High School, 2450 W. Ball Rd., Anaheim

- At least 10 staff members will attend (in person)
- Health/Resource Fair, open to the public

December 8, 3–7 p.m., Holiday Community Health Fair, hosted by County of Orange Supervisor Katrina Foley in partnership with CalOptima Health

The Shea Center, 26284 Oso Rd., San Juan Capistrano

- At least eight staff members will attend (in person)
- Health/Resource Fair, open to the public

December 9, 9 a.m.–4 p.m., 2025 Older Adult Mental Health Training for Professionals, hosted by Council on Aging

The County of Orange Behavioral Health Training Center, 750 The City Drive S., Orange

- At least two staff members will attend (in person)
- Health/Resource Fair, open to the public

December 13, 9 a.m.–1 p.m., CalOptima Health Holiday Resource Fair and Toy Distribution, hosted by CalOptima Health

CalOptima Health, 505 City Parkway W., Orange

- At least 20 staff members will attend (in person)
- Health/Resource Fair, open to the public

December 20, 8 a.m.–5 p.m., Christmas Together, hosted by Families Together of Orange County

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation Exhibitor/Attendee

Anaheim Convention Center, 800 W. Katella Ave., Anaheim

- Sponsorship fee: $15,000; includes a resource booth and logo placement on the main screen of the event.
- At least two staff members will 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 Board Action Agenda Referral

Action To Be Taken December 4, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

11. Approve Actions Related to CalOptima Health's Hospital Services Contracts with Acute Care Hospitals for Medi-Cal, OneCare, Program of All-Inclusive Care for the Elderly, and Covered California Programs

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions

1. Approve modifications to CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts, to address adding and terminating contracts with acute care hospitals.
2. Authorize the Chief Executive Officer, or designee, to execute amendments to the existing CalOptima Health Hospital Services Contracts to incorporate new language regarding obtaining CalOptima Health Board of Directors approval to add or terminate contracts with acute care hospitals for Medi-Cal, OneCare, Program of All-Inclusive Care for the Elderly, and Covered California programs, effective on or after February 1, 2026.

Background and Discussion

CalOptima Health's hospital provider partners are a vital part of its delivery system and support the care of nearly 900,000 members. As of November 14, 2025, CalOptima Health's network includes 42 acute care and rehabilitation hospitals.

In follow-up to discussions with CalOptima Health Board of Directors (Board) Vice-Chair Vicente Sarmiento, and Supervisor and alternate Board member Janet Nguyen, staff propose amendments to CalOptima Health policy EE.1141: CalOptima Health Provider Contracts, to require Board approval to add or terminate an acute care hospital from the CalOptima Health provider network.

The changes proposed herein also serve the purpose of addressing the request of Board Vice-Chair Sarmiento at the November 6, 2025, CalOptima Health Board of Directors meeting, to bring acute care hospital contract terminations to the Board for approval.

To implement this change, CalOptima Health staff will perform the actions below:

Policy Update

CalOptima Health Policy, EE.1141: CalOptima Health Provider Contracts, establishes the process by which CalOptima Health contracts or terminates contracts with providers to meet its state and federal obligations.

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CalOptima Health staff revised the policy as outlined in the table below and reflected in the attached redline policy, Attachment 3. The list below does not include all other regulatory required changes that are reflected in the Attachment.

Policy Section	**Proposed Change**
II. Policy, Section H	Adds language to require Board approval of the addition or termination of any contract with an acute care hospital.
III. Procedure, Section A.6	Includes procedural language to require Board approval before initiation of any new acute care hospital contract.
III. Procedure, Section E.1	Adds requirement to obtain Board approval of a contract termination with an acute care hospital prior to the formal letter of contract termination to the facility.

Hospital Services Contract Amendment
The proposed amendment, Attachment 2, incorporates a new contractual provision that requires formal approval from the Board for the addition or termination of any contract with an acute care hospital. CalOptima Health staff will distribute the amendment to all existing acute care hospitals and ensure the language is included in future hospital services contracts.

Fiscal Impact
The recommended actions are operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2025-26 Operating Budget.

Rationale for Recommendation
The above recommendations are responsive to requests by Board members and serve to support CalOptima Health's delivery system.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action
2. Hospital Services Contract Amendment
3. CalOptima Health Policy EE.1141, CalOptima Health Provider Contracts

/s/ Michael Hunn *11/25/2025*
Authorized Signature **Date**

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Attachment to the December 4, 2025 Board of Directors Meeting – Agenda Item 11

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AHMC Anaheim Regional Medical Center	100 N. Stoneman Ave. 2nd floor, Managed Care Dept.	Alhambra	CA	91801
Alta Newport Hospital, LLC. dba Foothill Regional Medical Center	3824 Hughes Ave.	Culver City	CA	90232
Anaheim Community Hospital, LLC	3350 W. Ball Rd.	Anahiem	CA	92804
Anaheim Global Medical Center, Inc. dba Anaheim Global Medical Center	1301 N. Tustin Ave.	Santa Ana	CA	92705
Chapman Global Medical Center, Inc. dba Chapman Global Medical Center	1301 N. Tustin Ave.	Santa Ana	CA	92705
CHCM, Inc. dba College Hospital Costa Mesa	301 Victoria St.	Costa Mesa	CA	90627
Children's Hospital at Mission	1201 W. La Veta Ave.	Orange	CA	92868
Childrens Hospital of Los Angeles	4650 Sunset Blvd.	Los Angeles	CA	90027
Children's Hospital of Orange County	1201 W. La Veta Ave.	Orange	CA	92868
City of Hope National Medical Center	1500 E. Duarte Rd.	Duarte	CA	91010
College Hospital Inc. dba College Hospital Cerritos	10802 College Place	Cerritos	CA	90703
Encompass Health Rehabilitation Hospital of Tustin, L.P dba Encompass Health Rehabilitation Hospital Of Tustin	9001 Liberty Parkway	Birmingham	AL	35242
Hoag Memorial Hospital Presbyterian	One Hoag Dr.	Newport Beach	CA	92663
Keck Medical Center of USC dba Keck Hospital of USC	1500 San Pablo St.	Los Angeles	CA	90033
Keck Medical Center of USC dba USC Kenneth Norris Jr. Hospital	1441 Eastlake Ave.	Los Angeles	CA	90033
MemorialCare Long Beach Medical Center	2840 Long Beach Blvd., Suite 405	Long Beach	CA	90806
MemorialCare Long Beach Medical Center dba MemorialCare Miller Children's and Women's Hospital Long Beach	2840 Long Beach Blvd., Suite 120	Long Beach	CA	90806
MemorialCare Orange Coast Medical Center	209851 Brookhurst St., Suite 107	Huntington Beach	CA	92646

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Name	Address	City	State	Zip Code
MemorialCare Saddleback Medical Center	24451 Health Center Dr.	Laguna Hills	CA	92653
Mission Hospital Regional Medical Center dba Providence Mission Hospital	3345 Michelson Dr., Suite 100	Irvine	CA	92612
Orange County Global Medical Center, Inc. dba Orange County Global Medical Center	1301 N. Tustin Ave.	Santa Ana	CA	92705
Pomona Valley Hospital Medical Center	1798 N. Garey Ave.	Pomona	CA	91767
South Coast Global Medical Center, Inc. dba South Coast Global Medical Center	1301 N. Tustin Ave.	Santa Ana	CA	92705
Southern California Specialty Care, LLC dba Kindred Hospital - La Mirada	680 South Fourth St., KH-5	Louisville	KY	40202
Southern California Specialty Care, LLC dba Kindred Hospital - Santa Ana	680 South Fourth St., KH-5	Louisville	KY	40202
St. Joseph Hospital, Orange dba Providence St. Joseph Hospital	3345 Michelson Dr., Suite 100	Irvine	CA	92612
St. Jude Hospital Inc. dba Providence St. Jude Medical Center	3345 Michelson Dr., Suite 100	Irvine	CA	92612
THC - Orange County, LLC dba Kindred Hospital - Brea	680 South Fourth Street, KH-5	Louisville	KY	40202
THC - Orange County, LLC dba Kindred Hospital - Westminster	680 South Fourth Street, KH-5	Louisville	KY	40202
The Regents of the University of California, as described in Article IX, Section 9 of the California Constitution, on behalf of UC Irvine Medical Center	333 City Blvd., West Suite 200	Orange	CA	92868
UCSD Medical Center	200 W. Arbor Dr.	San Diego	CA	92103
University of California, Irvine dba UCI Health - Fountain Valley	1400 South Douglas Rd. Suite 250	Anaheim	CA	92806
University of California, Irvine dba UCI Health - Los Alamitos	1400 South Douglas Rd. Suite 250	Anaheim	CA	92806
University of California, Irvine dba UCI Health - Placentia Linda	1400 South Douglas Rd. Suite 250	Anaheim	CA	92806
VSC HBO, LLC dba Healthbridge Children's Hospital	393 S. Tustin St.	Orange	CA	92866

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Name	Address	City	State	Zip Code
Whittier Hospital Medical Center Inc. dba Whittier Hospital Medical Center	100 N. Stoneman Ave., 2nd floor, Managed Care Dept.	Alhambra	CA	91801

AMENDMENT No. X TO
AMENDED AND RESTATED HOSPITAL SERVICES CONTRACT

This Amendment No. X to the Amended and Restated Hospital Services Contract ("**Amendment**") is effective as of February 1, 2026 ("**Effective Date**"), by and between Orange County Health Authority, a Public Agency, dba CalOptima ("**CalOptima**"), and [insert hospital name] ("**Hospital**"), with respect to the following:

RECITALS

A. CalOptima and Hospital entered into the Amended and Restated Hospital Services Contract ("**Contract**") under which Hospital has agreed to furnish certain items and services to CalOptima Members.

B. CalOptima and Hospital desire to amend certain terms of the Contract.

NOW, THEREFORE, the parties agree as follows:

1. A new Section 7.[X], **Additions and Terminations**, shall be added to the Contract, as follows:

   7.[X]. **Additions and Terminations.** The CalOptima Health board of directors approve the addition or termination of any contract with an acute care hospital.

2. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue 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. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract.

IN WITNESS WHEREOF, CalOptima and Hospital have executed this Amendment:

FOR HOSPIAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

Pending Board Approval

Policy:	EE.1141
Title:	**CalOptima Health Provider Contracts**
Department:	Contracting
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	02/01/2017
Revised Date:	12/01/2025
Applicable to:	☐ Administrative ☐ Covered California ☒ Medi-Cal ☒ OneCare ☒ PACE

For 2025 12/4 BOD Review Only

I. PURPOSE

This Policy establishes the process by which CalOptima Health contracts with Providers or establishes Letters of Agreement (LOAs), as appropriate with out-of-network Providers, to meet its State and Federal obligations regarding Network adequacy and Continuity of Care.

II. POLICY

A. CalOptima Health may enter into a contract for participation directly with a Provider to ensure access to Covered Services for Members.

B. CalOptima Health may contract with Providers that meet the participation requirements for applicable health care programs and are fully Credentialed by CalOptima Health in accordance with CalOptima Health Policies GG.1650: Credentialing and Recredentialing of Practitioners, and GG.1651: Assessment and Re-Assessment of Organizational Providers.

1. As a condition of contracting for the CalOptima Health Medi-Cal and CalOptima Health Program of All-Inclusive Care for the Elderly (PACE) programs, Providers:

   a. Must be enrolled in the State's Medi-Cal Program in accordance with the requirements set forth by the Department of Health Care Services (DHCS) and applicable All Plan Letters (APLs). Providers must also be enrolled in the State's Medi-Cal Program as a condition of providing Medi-Cal wrap around services not covered under the OneCare Medicare program.

   b. Must not be excluded from participation in, be suspended by, or have opted out of Medicare, nor be listed on the Centers for Medicare & Medicaid Services (CMS) Preclusion List, as provided in CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring.

2. Providers whose Medi-Cal enrollment is pending DHCS approval, CalOptima Health may extend a Provisional LOA for one hundred twenty (120) calendar days, allowing them to participate in a Network while their Medi-Cal application undergoes review, in accordance with DHCS APL-22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment.

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a. Should a Provider not receive Medi-Cal approval during the one hundred twenty (120) days, CalOptima Health will not re-initiate a contract with the Provider during the period in which the Provider re-submits its Medi-Cal enrollment application.

C. CalOptima Health shall determine Network adequacy by health care program and contract with those Provider types needed to, at a minimum, maintain an adequate Network as described in the requirements of each program. If CalOptima Health determines there is an unmet Provider coverage need which causes Member access issues and/or unmet Continuity of Care obligations, the CalOptima Health Contract Manager shall reach out to Providers, identified and through claims paid data, LOAs, Letters of Interest, or Member requests, and invite them to contract with CalOptima Health.

1. Network adequacy for the CalOptima Health Medi-Cal program shall include contracting for Managed Long Term Care Services and Supports (MLTSS) pursuant to DHCS requirements, and in accordance with CalOptima Health Policy EE.1135: Long-Term Care Facilities (LTCs) Contracting Requirements.

D. CalOptima Health shall use provider contract templates as approved by the CalOptima Health Board of Directors and DHCS based on Provider type. If necessary, CalOptima Health may contract for services at a rate that exceed levels approved by the CalOptima Health Board of Directors.

E. CalOptima Health shall execute a Single Case Agreement LOA with an out-of-network Provider where Medically Necessary, Covered Services to a Member are required as follows:

1. In order to access care not available through contracted Providers and where the Providers of the necessary services do not accept CalOptima Health's Non-Contracted Provider rates;

2. In order to meet network adequacy requirements in accordance with CalOptima Health policies effective at the time;

3. For Continuity of Care needs where the Provider will accept CalOptima Health's Board-approved contract rates, but does not wish to be a directly contracted CalOptima Health Provider; or

4. For Continuity of Care needs when the Provider will not accept CalOptima Health's Non-Contracted Provider rates, but transitioning the care to a contracted Provider:

a. Would require the Member to receive services from multiple Providers/facilities in an uncoordinated manner which would significantly impact the Member's condition; or

b. Could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment; or

c. Would require Member to undertake a substantial change in recommended treatment for Medically Necessary, Covered Services.

F. CalOptima Health shall comply with all applicable provisions of the DHCS All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members, including any subsequent guidance, and the laws referenced therein.

G. CalOptima Health shall not, by use of an exclusive provision, clause, agreement, or in any other manner, prohibit any Network Provider from providing services to Medi-Cal Members who are not

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a Member of CalOptima Health. This prohibition is not applicable to contracts entered into between CalOptima Health and Knox-Keene licensed health care service plans.

H. The CalOptima Health Board of Directors (BOD) shall approve the addition or termination of any contract with an acute care hospital.

III. PROCEDURE

A. Preliminary Evaluation

1. Providers who wish to contract with CalOptima Health's Medi-Cal program must be actively enrolled with Medi-Cal, for their National Provider Identifier (NPI) Type 1 and Type 2, as applicable. CalOptima Health procedures for verifying and screening Medi-Cal Provider enrollment, shall be conducted in accordance with CalOptima Health Policies GG.1650: Credentialing and Re-credentialing of Practitioners and GG.1651: Assessment and Reassessment of Organization Providers.

2. Physicians shall be required to meet the minimum physician standards as described in CalOptima Health Policy GG.1643: Minimum Physician Credentialing Standards and must complete a Credentialing application. The CalOptima Health Quality Improvement Department shall review and approve or deny the Credentialing application in accordance with CalOptima Health Policies GG.1643: Minimum Physician Credentialing Standards, and GG.1650: Credentialing and Recredentialing of Practitioners.

3. Health Delivery Organizations (HDOs) shall be required to complete a Credentialing application. The CalOptima Health Quality Improvement Department shall review and approve or deny the Credentialing application in accordance with CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers.

4. The Quality Improvement Department shall notify the Contracting and Provider Relations Departments when a Provider has been approved or denied Credentialing requirements.

5. If CalOptima Health denies Provider Credentialing, the following contractual-related notices shall be sent to the Provider after the Quality Improvement Department has notified the Provider of the credentialing denial:

   a. Contracting Department: Contracting shall notify the Provider that CalOptima Health will not be able to contract with the Provider.

   b. Provider Relations Department: If Credentialing has been denied for a new physician who is a provider in an existing CalOptima Health contracted physician group, the Provider Relations Department shall notify the contracted physician group that CalOptima Health will not be able to include the physician under the group contract.

6. The BOD shall approve the initiation of any new acute care hospital contract.

B. Provisional LOA

1. For Providers who demonstrate Medi-Cal registration is pending with DHCS, proof of completed submission will be accepted in lieu of enrollment status.

2. The Contracting Department will prepare and send a Provisional LOA that is valid for one hundred twenty (120) calendar days.

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a. The Contracting Department may extend the LOA for an additional sixty (60) calendar days, not to exceed one hundred eighty (180) days, to allow completion of the Medi-Cal enrollment process with DHCS.

3. Credentialing will communicate final status of Medi-Cal registration and credentialing, notifying the Contracting Department with the following Medi-Cal Registration and credentialing status:

a. Completed: the Contracting Department will replace the Provider's Provisional LOA with a full contract upon notification from Credentialing, and notify the Provider; or

b. Unsuccessful: the Contracting Department will terminate the one hundred twenty (120) calendar day Provisional LOA upon notification from Credentialing.

i. In instances of an unsuccessful Medi-Cal enrollment, the Provisional LOA will be terminated no later than fifteen (15) calendar days from DHCS' date of notification to the Provider.

ii. Re-initiation of the contract will only occur following provider notification to CalOptima Health of successful Medi-Cal enrollment.

C. Single Case Agreement LOA

1. CalOptima Health shall arrange for Medically Necessary, Covered Services to a Member through an out-of-network Provider when CalOptima Health is unable to provide services in the contracted Network, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals, or when it is necessary for purposes of Continuity of Care, in accordance with DHCS APL 23-022: Continuity of Care for Medi-Cal Beneficiaries who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, and for Medi-Cal Members who Transition into a New Medi-Cal Managed Health Plan on or After January 1, 2023 and Health and Safety Code, Section 1373.96.

a. For Non-Contracted Providers, rates shall be as specified in CalOptima Health Policies FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible and MA.3101: Claims Processing, unless the Chief Operating Officer approves other rates.

b. The Contracting Department must extend rates as specified in CalOptima Health Policies FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible and MA.3101: Claims Processing, unless different rates have been previously approved and demonstrate an attempt to negotiate if the Non-Contracted Provider declines to accept such rates.

c. The Contracting Department must obtain pre-approval from the Chief Operating Officer or assigned Designee for all LOAs negotiated at percent of billed charges.

2. Upon receipt of a completed LOA Request Form from CalOptima Health's Utilization Management, Long Term Services and Support (LTSS), Behavioral Health, or PACE Departments, approved by the Medical Director, or assigned Designee, CalOptima Health Contracting shall generate an LOA for:

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a. Medi-Cal: Out-of-network hospitals, physicians, ancillary, or other entities, as necessary, that do not accept CalOptima Health's Non-Contracted Provider rates as specified in CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible.

   i. If CalOptima Health has a DHCS-approved Alternative Access Standard for a Core Specialist(s), the LOA shall be offered to the Core Specialist(s) at no less than the Medi-Cal FFS rate, be agreed upon by CalOptima Health and the Provider, and must be made within the most recent year.

b. Medicare: Out-of-network OneCare, and PACE Providers that do not accept CalOptima Health's Non-Contracted Provider rates for these Medicare programs.

c. LTC: All Medi-Cal out-of-network long-term care facilities.

d. Whole Child Model (WCM): In accordance with DHCS APL 24-015: California Children's Service Whole Child Model Program, Inter-County Transfer CalOptima Health may need to enter into a one-time payment agreement with the Providers in the receiving county.

3. CalOptima Health may enter into an LOA with a Provider that is not enrolled in the State's Medi-Cal program if the Provider is needed for Continuity of care referrals or for access to care that is not available through CalOptima Health's contracted Provider network.

4. Once the LOA is fully executed, the Contracting Department shall send a notification of the completed LOA to internal departments, as applicable. The notification of a signed LOA is only for internal departments who have additional processes related to implementation.

D. Contract Completion

1. Upon notification from the Quality Improvement Department that a Provider's credentialing application has been approved, the Provider's contract shall be processed as follows:

   a. The Contracting Department shall offer the Provider a contract including program-based rates within approved limits set by the CalOptima Health Board of Directors.

   b. Providers shall be required to complete and return the Ownership and Control Disclosure form for inclusion in the contract, in accordance with DHCS APL 23-006: Delegation and Subcontractor Network Certification:

      i. Ensure the Contracted Provider completes all the required information, for each person with an ownership or control interest and for each managing employee.

      ii. Review to identify potential conflicts of interest. Alert Regulatory Affairs & Compliance (RAC) upon discovery of any conflict(s) of interest. The RAC Department has ten (10) business days, upon notification from the Contracting Department of the noncompliant Contracted Provider, to notify DHCS of the Contracted Provider's noncompliance.

   c. The Contract will be signed by the Provider and returned to CalOptima Health Contracting Department.

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d. The Contracting Department shall route the partially executed contract to the appropriate CalOptima Health signature authority for counter-signature in accordance with the CalOptima Health Policy GA.3202: CalOptima Health Signature Authority.

2. Once the contract is fully executed, the Contracting Department shall complete and forward a contract summary form to internal departments, as applicable. The Contract Summary is notice of a signed agreement only for internal departments who have additional processes related to implementation.

3. The Contracting Department shall assign the effective date as the first day of the month following the signature of both parties, unless:

   a. An effective date is specified in an applicable CalOptima Health Board Action Agenda Referral (COBAR); or

   b. Additional time is required for information systems programming.

4. Provider Relations: If a newly Credentialed physician is part of an existing contracted physician group, the Provider Relations Department shall assign the effective date as the first day of the month following approval notification from the Quality Improvement Department. The Provider Relations Department shall notify the Provider Data Operations Department to enter the physician into the CalOptima Health system of record (FACETS).

5. The Contracting Department shall notify the Provider of contract completion and forward the fully executed contract to the Provider.

E. Contract Termination

1. Prior to terminating an acute care hospital's participation in the CalOptima Health Network, the proposed termination must be approved by BOD.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicaid & Medicare Services (CMS) for OneCare
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Policy EE.1135: Long-Term Care Facilities (LTCFs) Contracting Requirements
E. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible
F. CalOptima Health Policy GA.3202: CalOptima Health Signature Authority
G. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
H. CalOptima Health Policy GG.1643: Minimum Physician Credentialing Standards
I. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
J. CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers
K. CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring
L. CalOptima Health Policy MA.3101: Claims Processing
~~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).

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~~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) 23-001: Network Certification Requirements (Supersedes APL 21-006)
~~O.~~P. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023 (Supersedes APL 22-032)
~~P.~~Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
~~Q.~~R. Department of Health and Human 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.~~S. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
~~S.~~T. Health and Safety Code, section 1373.96

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/22/2023	Department of Health Care Services (DHCS)	File and Use
06/13/2024	Department of Health Care Services (DHCS)	File and Use
08/06/2024	Department of Health Care Services (DHCS)	File and Use
05/14/2025	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/05/2007	Regular Meeting of the CalOptima Board of Directors
06/04/2009	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
04/04/2019	Regular Meeting of the CalOptima Board of Directors
12/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2017	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2017	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	04/04/2019	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2020	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2022	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	02/01/2023	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	04/01/2023	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	05/01/2023	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	12/01/2023	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	06/01/2024	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	08/01/2024	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	12/01/2024	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	02/01/2025	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	05/01/2025	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	12/01/2025	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Alternative Access Standard (AAS)	An alternative to the existing access standard approved by DHCS when a managed care plan has exhausted all other reasonable options for obtaining providers in order to meet the applicable standards, or if DHCS determines that the requesting managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.
Continuity of Care	Medi-Cal: Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship. OneCare: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; 5. Appropriate discharge planning; and 6. Timely placement at different levels of care including hospital, skilled nursing and home health care.
Core Specialist	Adult and pediatric providers as specified in Department of Health Care Services All-Plan Letter 20-003: Network Certification Requirements, including Cardiology/Interventional Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology, HIV/AIDS Specialists/Infectious Diseases, Nephrology, Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Physical Medicine, Rehabilitation, Psychiatry, and Pulmonology.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age.

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Term	Definition
	CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living;

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Term	Definition
	16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract. PACE: For the purposes of this policy, defined as those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Participants under the provisions of Welfare & Institutions Code Section 14132 and the CalOptima Health PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Credentialing	Medi-Cal & OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.
Department of Health Care Services (DHCS)	Medi-Cal & OneCare: The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation. PACE: The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Health Delivery Organization (HDO)	Includes hospitals, home health agencies, skilled nursing facilities, extended care facilities, nursing homes, and free-standing surgical, laboratory, or other centers.
Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.
Letter of Interest	A letter received by CalOptima Health from an entity that is interested in contracting with CalOptima Health to provide services covered under one or more CalOptima Health Programs.
Medically Necessary	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

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Term	Definition
	standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. 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 include 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.
Network	Primary Care Providers, Specialists, hospitals, pharmacy, ancillary Providers, facilities, and any other Providers that subcontract with CalOptima Health for the delivery of Covered Services.
Non-Contracted Provider	A Provider who is not obligated by written contract to provide Covered Services to a Member.
Preclusion List	CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.
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) 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.
Provisional Letter of Agreement (LOA)	Provider must demonstrate they are Medi-Cal enrolled or in the process of being enrolled. Provider has initiated the CalOptima Health credentialing process. Provider may actively provide services to Members under qualifying for Continuity of Care, as applicable, upon receiving authorization from the Utilization Management (UM) department. Valid for 120 days from effective date, and may be used for multiple Members.
Single Case Agreement Letter of Agreement (LOA)	Services must be prior authorized by the UM department. Authorization number and contracted services must be defined on the LOA. Valid for one (1) year from the UM date, and is a one-time agreement for a single Member.

For 20251204 BOD Review Only

Policy:	EE.1141
Title:	**CalOptima Health Provider Contracts**
Department:	Contracting
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	02/01/2017
Revised Date:	12/01/2025
Applicable to:	☐ Administrative ☐ Covered California ☒ Medi-Cal ☒ OneCare ☒ PACE

For 2025 12/4 BOD Review Only

I. PURPOSE

This Policy establishes the process by which CalOptima Health contracts with Providers or establishes Letters of Agreement (LOAs), as appropriate with out-of-network Providers, to meet its State and Federal obligations regarding Network adequacy and Continuity of Care.

II. POLICY

A. CalOptima Health may enter into a contract for participation directly with a Provider to ensure access to Covered Services for Members.

B. CalOptima Health may contract with Providers that meet the participation requirements for applicable health care programs and are fully Credentialed by CalOptima Health in accordance with CalOptima Health Policies GG.1650: Credentialing and Recredentialing of Practitioners, and GG.1651: Assessment and Re-Assessment of Organizational Providers.

1. As a condition of contracting for the CalOptima Health Medi-Cal and CalOptima Health Program of All-Inclusive Care for the Elderly (PACE) programs, Providers:

   a. Must be enrolled in the State's Medi-Cal Program in accordance with the requirements set forth by the Department of Health Care Services (DHCS) and applicable All Plan Letters (APLs). Providers must also be enrolled in the State's Medi-Cal Program as a condition of providing Medi-Cal wrap around services not covered under the OneCare Medicare program.

   b. Must not be excluded from participation in, be suspended by, or have opted out of Medicare, nor be listed on the Centers for Medicare & Medicaid Services (CMS) Preclusion List, as provided in CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring.

2. Providers whose Medi-Cal enrollment is pending DHCS approval, CalOptima Health may extend a Provisional LOA for one hundred twenty (120) calendar days, allowing them to participate in a Network while their Medi-Cal application undergoes review, in accordance with DHCS APL-22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment.

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a. Should a Provider not receive Medi-Cal approval during the one hundred twenty (120) days, CalOptima Health will not re-initiate a contract with the Provider during the period in which the Provider re-submits its Medi-Cal enrollment application.

C. CalOptima Health shall determine Network adequacy by health care program and contract with those Provider types needed to, at a minimum, maintain an adequate Network as described in the requirements of each program. If CalOptima Health determines there is an unmet Provider coverage need which causes Member access issues and/or unmet Continuity of Care obligations, the CalOptima Health Contract Manager shall reach out to Providers, identified and through claims paid data, LOAs, Letters of Interest, or Member requests, and invite them to contract with CalOptima Health.

1. Network adequacy for the CalOptima Health Medi-Cal program shall include contracting for Managed Long Term Care Services and Supports (MLTSS) pursuant to DHCS requirements, and in accordance with CalOptima Health Policy EE.1135: Long-Term Care Facilities (LTCs) Contracting Requirements.

D. CalOptima Health shall use provider contract templates as approved by the CalOptima Health Board of Directors and DHCS based on Provider type. If necessary, CalOptima Health may contract for services at a rate that exceed levels approved by the CalOptima Health Board of Directors.

E. CalOptima Health shall execute a Single Case Agreement LOA with an out-of-network Provider where Medically Necessary, Covered Services to a Member are required as follows:

1. In order to access care not available through contracted Providers and where the Providers of the necessary services do not accept CalOptima Health's Non-Contracted Provider rates;

2. In order to meet network adequacy requirements in accordance with CalOptima Health policies effective at the time;

3. For Continuity of Care needs where the Provider will accept CalOptima Health's Board-approved contract rates, but does not wish to be a directly contracted CalOptima Health Provider; or

4. For Continuity of Care needs when the Provider will not accept CalOptima Health's Non-Contracted Provider rates, but transitioning the care to a contracted Provider:

a. Would require the Member to receive services from multiple Providers/facilities in an uncoordinated manner which would significantly impact the Member's condition; or

b. Could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment; or

c. Would require Member to undertake a substantial change in recommended treatment for Medically Necessary, Covered Services.

F. CalOptima Health shall comply with all applicable provisions of the DHCS All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members, including any subsequent guidance, and the laws referenced therein.

G. CalOptima Health shall not, by use of an exclusive provision, clause, agreement, or in any other manner, prohibit any Network Provider from providing services to Medi-Cal Members who are not

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a Member of CalOptima Health. This prohibition is not applicable to contracts entered into between CalOptima Health and Knox-Keene licensed health care service plans.

H. The CalOptima Health Board of Directors (BOD) shall approve the addition or termination of any contract with an acute care hospital.

III. PROCEDURE

A. Preliminary Evaluation

1. Providers who wish to contract with CalOptima Health's Medi-Cal program must be actively enrolled with Medi-Cal, for their National Provider Identifier (NPI) Type 1 and Type 2, as applicable. CalOptima Health procedures for verifying and screening Medi-Cal Provider enrollment, shall be conducted in accordance with CalOptima Health Policies GG.1650: Credentialing and Re-credentialing of Practitioners and GG.1651: Assessment and Reassessment of Organization Providers.

2. Physicians shall be required to meet the minimum physician standards as described in CalOptima Health Policy GG.1643: Minimum Physician Credentialing Standards and must complete a Credentialing application. The CalOptima Health Quality Improvement Department shall review and approve or deny the Credentialing application in accordance with CalOptima Health Policies GG.1643: Minimum Physician Credentialing Standards, and GG.1650: Credentialing and Recredentialing of Practitioners.

3. Health Delivery Organizations (HDOs) shall be required to complete a Credentialing application. The CalOptima Health Quality Improvement Department shall review and approve or deny the Credentialing application in accordance with CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers.

4. The Quality Improvement Department shall notify the Contracting and Provider Relations Departments when a Provider has been approved or denied Credentialing requirements.

5. If CalOptima Health denies Provider Credentialing, the following contractual-related notices shall be sent to the Provider after the Quality Improvement Department has notified the Provider of the credentialing denial:

   a. Contracting Department: Contracting shall notify the Provider that CalOptima Health will not be able to contract with the Provider.

   b. Provider Relations Department: If Credentialing has been denied for a new physician who is a provider in an existing CalOptima Health contracted physician group, the Provider Relations Department shall notify the contracted physician group that CalOptima Health will not be able to include the physician under the group contract.

6. The BOD shall approve the initiation of any new acute care hospital contract.

B. Provisional LOA

1. For Providers who demonstrate Medi-Cal registration is pending with DHCS, proof of completed submission will be accepted in lieu of enrollment status.

2. The Contracting Department will prepare and send a Provisional LOA that is valid for one hundred twenty (120) calendar days.

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a. The Contracting Department may extend the LOA for an additional sixty (60) calendar days, not to exceed one hundred eighty (180) days, to allow completion of the Medi-Cal enrollment process with DHCS.

3. Credentialing will communicate final status of Medi-Cal registration and credentialing, notifying the Contracting Department with the following Medi-Cal Registration and credentialing status:

a. Completed: the Contracting Department will replace the Provider's Provisional LOA with a full contract upon notification from Credentialing, and notify the Provider; or

b. Unsuccessful: the Contracting Department will terminate the one hundred twenty (120) calendar day Provisional LOA upon notification from Credentialing.

i. In instances of an unsuccessful Medi-Cal enrollment, the Provisional LOA will be terminated no later than fifteen (15) calendar days from DHCS' date of notification to the Provider.

ii. Re-initiation of the contract will only occur following provider notification to CalOptima Health of successful Medi-Cal enrollment.

C. Single Case Agreement LOA

1. CalOptima Health shall arrange for Medically Necessary, Covered Services to a Member through an out-of-network Provider when CalOptima Health is unable to provide services in the contracted Network, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals, or when it is necessary for purposes of Continuity of Care, in accordance with DHCS APL 23-022: Continuity of Care for Medi-Cal Beneficiaries who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, and for Medi-Cal Members who Transition into a New Medi-Cal Managed Health Plan on or After January 1, 2023 and Health and Safety Code, Section 1373.96.

a. For Non-Contracted Providers, rates shall be as specified in CalOptima Health Policies FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible and MA.3101: Claims Processing, unless the Chief Operating Officer approves other rates.

b. The Contracting Department must extend rates as specified in CalOptima Health Policies FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible and MA.3101: Claims Processing, unless different rates have been previously approved and demonstrate an attempt to negotiate if the Non-Contracted Provider declines to accept such rates.

c. The Contracting Department must obtain pre-approval from the Chief Operating Officer or assigned Designee for all LOAs negotiated at percent of billed charges.

2. Upon receipt of a completed LOA Request Form from CalOptima Health's Utilization Management, Long Term Services and Support (LTSS), Behavioral Health, or PACE Departments, approved by the Medical Director, or assigned Designee, CalOptima Health Contracting shall generate an LOA for:

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a. Medi-Cal: Out-of-network hospitals, physicians, ancillary, or other entities, as necessary, that do not accept CalOptima Health's Non-Contracted Provider rates as specified in CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible.

   i. If CalOptima Health has a DHCS-approved Alternative Access Standard for a Core Specialist(s), the LOA shall be offered to the Core Specialist(s) at no less than the Medi-Cal FFS rate, be agreed upon by CalOptima Health and the Provider, and must be made within the most recent year.

b. Medicare: Out-of-network OneCare, and PACE Providers that do not accept CalOptima Health's Non-Contracted Provider rates for these Medicare programs.

c. LTC: All Medi-Cal out-of-network long-term care facilities.

d. Whole Child Model (WCM): In accordance with DHCS APL 24-015: California Children's Service Whole Child Model Program, Inter-County Transfer CalOptima Health may need to enter into a one-time payment agreement with the Providers in the receiving county.

3. CalOptima Health may enter into an LOA with a Provider that is not enrolled in the State's Medi-Cal program if the Provider is needed for Continuity of care referrals or for access to care that is not available through CalOptima Health's contracted Provider network.

4. Once the LOA is fully executed, the Contracting Department shall send a notification of the completed LOA to internal departments, as applicable. The notification of a signed LOA is only for internal departments who have additional processes related to implementation.

D. Contract Completion

1. Upon notification from the Quality Improvement Department that a Provider's credentialing application has been approved, the Provider's contract shall be processed as follows:

   a. The Contracting Department shall offer the Provider a contract including program-based rates within approved limits set by the CalOptima Health Board of Directors.

   b. Providers shall be required to complete and return the Ownership and Control Disclosure form for inclusion in the contract, in accordance with DHCS APL 23-006: Delegation and Subcontractor Network Certification:

      i. Ensure the Contracted Provider completes all the required information, for each person with an ownership or control interest and for each managing employee.

      ii. Review to identify potential conflicts of interest. Alert Regulatory Affairs & Compliance (RAC) upon discovery of any conflict(s) of interest. The RAC Department has ten (10) business days, upon notification from the Contracting Department of the noncompliant Contracted Provider, to notify DHCS of the Contracted Provider's noncompliance.

   c. The Contract will be signed by the Provider and returned to CalOptima Health Contracting Department.

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d. The Contracting Department shall route the partially executed contract to the appropriate CalOptima Health signature authority for counter-signature in accordance with the CalOptima Health Policy GA.3202: CalOptima Health Signature Authority.

2. Once the contract is fully executed, the Contracting Department shall complete and forward a contract summary form to internal departments, as applicable. The Contract Summary is notice of a signed agreement only for internal departments who have additional processes related to implementation.

3. The Contracting Department shall assign the effective date as the first day of the month following the signature of both parties, unless:

   a. An effective date is specified in an applicable CalOptima Health Board Action Agenda Referral (COBAR); or

   b. Additional time is required for information systems programming.

4. Provider Relations: If a newly Credentialed physician is part of an existing contracted physician group, the Provider Relations Department shall assign the effective date as the first day of the month following approval notification from the Quality Improvement Department. The Provider Relations Department shall notify the Provider Data Operations Department to enter the physician into the CalOptima Health system of record (FACETS).

5. The Contracting Department shall notify the Provider of contract completion and forward the fully executed contract to the Provider.

E. Contract Termination

1. Prior to terminating an acute care hospital's participation in the CalOptima Health Network, the proposed termination must be approved by BOD.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicaid & Medicare Services (CMS) for OneCare
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Policy EE.1135: Long-Term Care Facilities (LTCFs) Contracting Requirements
E. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible
F. CalOptima Health Policy GA.3202: CalOptima Health Signature Authority
G. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
H. CalOptima Health Policy GG.1643: Minimum Physician Credentialing Standards
I. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
J. CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers
K. CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring
L. CalOptima Health Policy MA.3101: Claims Processing
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Supersedes APL 16-001).

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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) 23-001: Network Certification Requirements (Supersedes APL 21-006)
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023 (Supersedes APL 22-032)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
R. Department of Health and Human 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)
S. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
T. Health and Safety Code, section 1373.96

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/22/2023	Department of Health Care Services (DHCS)	File and Use
06/13/2024	Department of Health Care Services (DHCS)	File and Use
08/06/2024	Department of Health Care Services (DHCS)	File and Use
05/14/2025	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/05/2007	Regular Meeting of the CalOptima Board of Directors
06/04/2009	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
04/04/2019	Regular Meeting of the CalOptima Board of Directors
12/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2017	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2017	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	04/04/2019	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2020	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2022	EE.1141	CalOptima Provider Contracts	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	02/01/2023	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	04/01/2023	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	05/01/2023	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	12/01/2023	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	06/01/2024	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	08/01/2024	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	12/01/2024	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	02/01/2025	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	05/01/2025	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE
Revised	12/01/2025	EE.1141	CalOptima Health Provider Contracts	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Alternative Access Standard (AAS)	An alternative to the existing access standard approved by DHCS when a managed care plan has exhausted all other reasonable options for obtaining providers in order to meet the applicable standards, or if DHCS determines that the requesting managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.
Continuity of Care	Medi-Cal: Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship. OneCare: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; 5. Appropriate discharge planning; and 6. Timely placement at different levels of care including hospital, skilled nursing and home health care.
Core Specialist	Adult and pediatric providers as specified in Department of Health Care Services All-Plan Letter 20-003: Network Certification Requirements, including Cardiology/Interventional Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology, HIV/AIDS Specialists/Infectious Diseases, Nephrology, Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Physical Medicine, Rehabilitation, Psychiatry, and Pulmonology.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age.

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Term	Definition
	CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living;

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Term	Definition
	16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract. PACE: For the purposes of this policy, defined as those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Participants under the provisions of Welfare & Institutions Code Section 14132 and the CalOptima Health PACE Program Agreement, except those services specifically excluded under the Exhibit E, Attachment 1, Section 26 of the PACE Program Agreement.
Credentialing	Medi-Cal & OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.
Department of Health Care Services (DHCS)	Medi-Cal & OneCare: The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation. PACE: The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Health Delivery Organization (HDO)	Includes hospitals, home health agencies, skilled nursing facilities, extended care facilities, nursing homes, and free-standing surgical, laboratory, or other centers.
Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.
Letter of Interest	A letter received by CalOptima Health from an entity that is interested in contracting with CalOptima Health to provide services covered under one or more CalOptima Health Programs.
Medically Necessary	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

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Term	Definition
	standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. 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 include 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.
Network	Primary Care Providers, Specialists, hospitals, pharmacy, ancillary Providers, facilities, and any other Providers that subcontract with CalOptima Health for the delivery of Covered Services.
Non-Contracted Provider	A Provider who is not obligated by written contract to provide Covered Services to a Member.
Preclusion List	CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.
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) 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.
Provisional Letter of Agreement (LOA)	Provider must demonstrate they are Medi-Cal enrolled or in the process of being enrolled. Provider has initiated the CalOptima Health credentialing process. Provider may actively provide services to Members under qualifying for Continuity of Care, as applicable, upon receiving authorization from the Utilization Management (UM) department. Valid for 120 days from effective date, and may be used for multiple Members.
Single Case Agreement Letter of Agreement (LOA)	Services must be prior authorized by the UM department. Authorization number and contracted services must be defined on the LOA. Valid for one (1) year from the UM date, and is a one-time agreement for a single Member.

For 2025 12 04 BOD Review Only

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

OWNERSHIP AND DISCLOSURE FORM

Completing and submitting the Ownership and Disclosure Form is a condition of participating in the CalOptima Health network. Failure to submit the requested information may result in the denial of entering into a provider contract or the termination of a current one.

Purpose:

Pursuant to Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006, Medi-Cal managed care plans, such as CalOptima Health, must comply with the ownership and control disclosure requirements as set forth in 42 Code of Federal Regulations (CFR) § 455.104 by collecting information on whether their subcontractors are persons with ownership or control controlling interests or managing employees. The provider will complete and return this form in accordance with CalOptima Health's instructions prior to the contract effective date. The provider will also submit updates to this form to CalOptima Health within 30 days of any change.

Types of providers required to complete the Ownership and Disclosure Form:
Providers that apply as a partnership, corporation, governmental entity or nonprofit organization must disclose ownership or control information as required by Title 42 of the CFR, Section 455.104. Examples include, but are not limited to, hospitals, nursing homes, community mental health centers, managed care organizations and fiscal agents.

Types of providers exempt from completing the Ownership and Disclosure Form:
Providers who are unincorporated sole proprietors are not required to disclose the ownership or control information described in Title 42 of the CFR Section 455.104. Examples include solo practitioners, a group of individual practitioners, or those entirely state or federally funded.

Definitions as outlined in 42 CFR 455.101:

1. **Control Interest** (person with an ownership or control interest): A person or corporation that has an ownership interest totaling 5 percent or more in a disclosing entity.
2. **Disclosing Entity:** A provider (other than an unincorporated solo proprietor, group of individual practitioners, or those entirely state or federally funded) or fiscal agent.
3. **Fiscal Agent:** A contractor who processes or pays vendor claims on behalf of the agency.
4. **Group of Practitioners:** Two or more health care practitioners who practice their profession at a common location (whether they share common facilities, supporting staff or equipment).
5. **Managing Employee:** An individual who makes day-to-day decisions on behalf of the provider entity.
6. **Ownership Interest:** The possession of equity in the capital, stock or profits of the disclosing entity.
7. **Provider Entity:** A health care provider or supplier who bills Medi-Cal or Medicare for services rendered and has a National Provider Identifier (NPI) number.
8. **Subcontractor:** An individual, agency or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients.
9. **Solo Proprietor:** One person owns and operates the business, with no legal distinction between the owner and the business.

Instructions:

1. Read each section throughout the form and enter the requested information.
2. Answer all questions as of the current date, i.e., request date.
3. If there is no information to include, indicate “none” or “Not Applicable” (N/A) in the space provided. Do not leave blank spaces.
4. If more space is needed, please attach additional sheets as necessary.

The Ownership and Disclosure Form must be submitted at the following times:

1. At the initial request to contract with CalOptima Health.
2. Within 30 days after any change in ownership of the disclosing entity.
3. Upon request by CalOptima Health during the recredentialing process or as specified in regulation 455.414, as requested by CalOptima Health.

Please enter the entity information below:

1. Provider Entity Information	
Name of Entity:	
Doing Business As (DBA): *(If applicable)*	**NPI Number:**
Federal Tax ID (TIN):	**Social Security Number (SSN):** *(If applicable)*
Practice Address:	**City, State, Zip**
Please select the option that best describes the provider entity	
☐ **Unincorporated solo proprietor/group of individual practitioners, entirely state or federally funded** Check if your provider type is exempt from completing the disclosure form. i.e., solo practitioner, solo group of individuals ***If this box is checked, sections 2 through 4 do not apply.*** **Please sign and date the document.**	☐ **Organization ownership** Check if your provider type is required to complete the disclosure form, i.e., disclosing entity, hospitals, nursing homes ***If this box is checked, sections 2 through 4 apply.*** **Please sign and date the document.**

2. List the Names of Board of Directors, Directors, General Partners, Managing Employee, Officers			
Name	**Title**	**Name**	**Title**

3. Ownership and Control Information

Individuals with ownership or control interest owning more than 5 percent of the provider's stock:
List all individuals with an ownership or control interest. Include each person's name, address, date of birth (DOB) and SSN. Also, indicate the title (e.g., Chief Executive Officer, owner) and, if an owner, the percent of ownership.

Name	**Title**	**% of Ownership**	**DOB**	**SSN**	**Address (Street/City/State/Zip)**

Is any person listed above related to another as a spouse, parent, child or sibling? Yes ☐ No ☐
If yes, list the names of individuals listed above who are related to each other.

Name	**Relationship**	**Name of Person Related to**

Organizations with an ownership or control interest holding more than 5 percent of the provider's debt:

List all organizations with an ownership or control interest. Include the TIN, percent of ownership, primary business address, every business location and P.O. Box address(es).

Name	Title	% of Ownership	DOB	TIN	Address or P.O. Box (Street/City/State/Zip)

4. Suspension and Debarment

Have you, any of your employees or any individuals who have ownership and/or controlling interest in the disclosing entity ever been placed on the Federal Office of Inspector General Health and Human Services (OIG/HHS) exclusions list or otherwise been suspended or debarred from participation in Medi-Cal or Medicare programs? No ☐ Yes ☐ If yes, list below.

Please check the OIG for excluded individuals: exclusions.oig.hhs.gov.

Name	Exclusion Date	Exclusion Reason

Any designated representative of the organization may complete and sign this form on behalf of the organization.

The undersigned hereby certifies that the following information regarding PROVIDER (the "Provider") is true and correct as of the date set forth below:

Print Name of Authorized Representative (First, Last)	Signature
Title	**Date**

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 4, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

12. Approve Modifications to CalOptima Health Contracting Policy EE.1116, Contracted Provider Notification to CalOptima Health of Changes Affecting the Legal Status of the Contract

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions

Approve modifications to CalOptima Health Policy EE.1116, Contracted Provider Notification to CalOptima Health of Changes Affecting the Legal Status of the Contract

Background

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

Discussion

The CalOptima Health Board of Directors (Board) reviewed and approved CalOptima Health Policy EE.1116, Contracted Provider Notification to CalOptima Health of Changes Affecting the Legal Status of the Contract, on February 3, 2022. The policy describes the process for a contracted provider to notify CalOptima Health of certain changes affecting the legal status of their contract and how such changes, as bulleted below, are managed by CalOptima Health:

- Change of National Provider Identifier (NPI) and/or Tax Identification Number (TIN)
- Change of ownership, directors, or trustees
- Change of contracted provider's legal or "doing business as" (dba) name
- Changes in availability or location of services (*i.e.*, closure of company or location(s) that are listed in provider's contract, new location)
- Changes to notice address, and
- Retirement or death of a professional with an individual contract

CalOptima Health staff proposes revising this policy to provide clear policy guidance, improve readability, and ensure alignment with other CalOptima policies. The table below lists recommended substantive changes to the policy that are reflected in Attachment 1. The list does not include non-substantive changes that are reflected in the attachment (*e.g.*, formatting, spelling, punctuation, capitalization, minor clarifying language, and/or grammatical changes).

Policy Section	Proposed Change	Rationale
I.	Add language regarding compliance with state and federal regulations	Ensures alignment with other Contracting department policies
II.A.	Add language requiring Contracted Providers to promptly report changes to their contract	Ensures requirement to promptly notify CalOptima Health is delineated at the beginning of the policy in accordance with

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		Department of Health Care Services requirements
II.B.	Edit language for consistency in structure	Improves readability and understanding of policy
III.A.	Outline preliminary evaluation steps taken by CalOptima Health's Contracting Department	Ensures identification of impacts or Provider contract changes and next steps for CalOptima Health
III.B., C., D., and E.	Reorganize requirements into sections that address the need for a new Provider contract, contract amendment, assignment and assumption transfer, or contract termination	Improves readability and understanding of appropriate steps for each scenario
III.F.	Refine language related to final distribution of Provider contract, amendment, assignment agreement, or termination notice to CalOptima Health departments	Improves readability and understanding of policy
V.	Add appropriate policy and DHCS references	Provides appropriate references to controlling sources
IX.	Add and revise definitions	Ensures alignment with other Contracting Department policies

To ensure CalOptima Health's commitment to providing clear and consistent policy guidance, CalOptima Health staff seek Board approval of the revised version of this policy.

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 2025-26 Operating Budget.

Rationale for Recommendation
The policy changes provide clarity, align policies with current operations, and expound on status changes that would necessity a contractual change.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Health Policy EE.1116: Contracted Provider Notification to CalOptima Health of Changes Affecting the Legal Status of the Contract

Michael Hunn *11/25/2025*
Authorized Signature **Date**

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Policy:	EE.1116
Title:	**Contracted Provider Notification to CalOptima Health of Changes Affecting the Legal Status of the Contract**
Department:	Contracting
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	02/03/2022
Revised Date:	12/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 2025 1204 BOD Review Only

I. PURPOSE

This policy ~~defines~~establishes the process and outlines the requirements for ~~a~~ Contracted ~~Provider~~Providers to notify CalOptima Health of any changes affecting their legal status, in compliance with both state and federal regulations.

II. POLICY

A. ~~A~~CalOptima Health requires all contracted Providers to promptly report any changes to their contract, in accordance with our contract with the Department of Health Care Services (DHCS) and All Plan Letters (APLs).

~~A.~~B. CalOptima Health requires Contracted ~~Provider shall~~Providers to submit a written notification to the Contracting Department, in accordance with the terms ~~in~~of their contract ~~to the CalOptima Health Contracting Department of a proposed change(s), for changes~~ that may impact ~~Provider's~~their contract ~~with CalOptima Health~~. Such changes include, but are not limited to:

1. ~~Change of~~Changes to National Provider Identifier (NPI) and/or Tax Identification Number (TIN);

2. ~~Change of Ownership~~Changes to ownership, directors, or trustees;

3. ~~Change of~~Changes to Contracted Provider's legal or "doing business as" (dba) name;

4. Changes ~~in~~to availability or location of services (i.e., closure of company or location(s) that are listed in Provider's contract; new location);

5. Changes to Notice Address; and

6. ~~Retirement~~Changes to staffing due to the retirement or death of a professional with an individual contract.

III. PROCEDURE

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A. ~~Upon receipt of notification~~Preliminary Evaluation

1. The Contracting Department receives notice from a ~~Contracted~~ Provider ~~of~~regarding changes to their legal status.

a. Upon receipt of Provider's notice, the Contracting Department shall:

i. ~~Send an acknowledgment letter~~ Provide confirmation to the ~~Contracted~~ Provider ~~indicating~~that includes the ~~date of~~ receipt~~, estimated time for~~ date, expected review time, and ~~a request for~~any additional information~~, as applicable.~~ that may be needed.

~~B. Identify necessary updates to the contract:~~

ii. ~~Prior to initiating contract changes, the~~Identify applicable revisions to their legal status, for example, initiating a new contract, assignment agreement, issuing a contract amendment, proceeding with a contract termination, or confirming that no contractual action is required.

iii. Identify operational impacts to the organization.

a) Impacts Network Adequacy: The Contracting Department ~~**shall:**~~will attempt to recruit for additional providers;

~~1. Determine if CalOptima Health Board of Directors (BOD) action is required.~~

~~i. If BOD action is required, consult Legal Counsel and other impacted departments as applicable, develop a CalOptima Health Board Action Agenda Referral (COBAR), and seek BOD approval;~~

b) ~~**Determine if approvals are needed from departments such as**~~Impacts Internal Departments: The Contracting Department will coordinate with Delegation Oversight, Quality Improvement, or Medical Management, and obtain such approval; and

~~2. Notify the Provider Relations and Customer Service Departments immediately of any proposed changes that impact Primary Care Provider (PCP) Member assignments.~~

c) ~~**If the**~~Impacts Network Operations: The Contracting Department ~~**determines that the change(s) materially modifies the Contracted Provider's contract, the**~~will assess if Board of Directors (BOD) action is required. The Contracting Department ~~**may:**~~ will consult with legal counsel and other relevant departments as applicable, submit a CalOptima Health Board Action Agenda Referral (COBAR), and seek BOD approval.

B. ~~Initiate~~Changes That Require a New Contract

~~1.~~ The Contracting Department shall initiate a new contract when there is a new legal entity (i.e., new NPI, tax ID). These changes signify a material change in the Provider's legal identity and therefore require a new contract~~,~~ to ensure compliance with CalOptima Health's contracting standards. The new contract shall be executed in accordance with CalOptima Health ~~Policy~~Policies, EE.1141: CalOptima Health Provider Contracts~~.~~

For 2025 12/4 BOD Review Only

~~a. Situations that might constitute a new contract:~~

~~a) Change or new Provider NPI;~~

~~b) Change or new Provider TIN;~~

~~c) Change in ownership; or~~

1. ~~Change in legal name.~~ and GG.1650: Credentialing and Recredentialing of Practitioners.

~~b.~~a. The Contracting Department shall make best efforts to align the termination date of the ~~current~~Provider's existing contract to that of the effective date of the Provider's new contract to ensure continuity~~,~~ when applicable.

~~2. Initiate an Assignment Agreement for a change that does not require a new CalOptima Health contract. Situations that might constitute a new Assignment Agreement include but are not limited to: transfer of the selling Provider's contractual rights and obligations to the acquiring Provider. The Quality Improvement Department shall review the Centers for Medicare & Medicaid Services (CMS) Preclusion List and other primary sources to ensure that the new owner(s) is not excluded from participation in Medicare or Medi-Cal programs as listed in CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners.~~

C. ~~Initiate~~Changes That Require an Amendment

~~3.~~ The Contracting Department shall initiate an amendment to the ~~Contracted~~ Provider's ~~current~~ contract ~~for~~when changes are not related to the legal entity, such as updates to the ownership ~~and disclosure form~~, directors, or ~~changes that do not change the Contracted~~trustees, to the Provider's ~~legal or dba name, TIN, or NPI, such as, a change in legal or dba name, change in~~ Notice ~~address,~~ Address, or the addition or ~~deletion of a service location (in the case of ancillary providers) that may be listed in Contracted Provider's contract.~~

~~4.~~1. ~~If a Contracted Provider's contract lists service~~ removal of service locations~~, and a Contracted Provider is requesting that a new service location be added to the contract, the Contracting Department shall inform the Provider Relations Department to obtain the necessary credentialing documents and submit the documents to the Quality Improvement Department for the new service location. If applicable, an amendment will be sent to Contracted Provider for signature after the Contracting Department receives notification from the Quality Improvement Department that the service location is credentialed~~.

~~c. Initiate a contract termination for Contracted Provider's current contract.~~

~~i. Situations that might constitute a contract termination:~~

~~a) Retirement of a Contracted Provider with an individual contract;~~

~~b) Death of a Contracted Provider with an individual contract;~~

~~c) Closure of the Contracted Provider's service location(s); or~~

~~d) Ownership change.~~

For 2025-1204 POD Review Only

D. Changes That Require an Assignment and Assumption

1. The Contracting Department shall ~~send a contract~~initiate an Assignment and Assumption to transfer of contractual rights and obligations from a selling Provider to an acquiring Provider. contract.

a. The acquiring Provider must meet the credentialing requirements in accordance with CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners.

E. Changes That Require a Contract Termination

1. The Contracting Department shall initiate a termination due to the retirement or death of a professional with a solo contract, a request to assign is declined or the Provider is relocating out of CalOptima Health's service area.

~~c.~~a. The termination ~~notification letter to Provider,~~is processed in accordance with the terms ~~in Provider's~~of the contract and CalOptima Health policies and DHCS APL 21-003: Medi-Cal Network Provider and Subcontractor Terminations. This process includes a formal termination letter that references the applicable provision in the provider contract.

~~2. If the Contracting Department determines that the change does not materially modify the contract, but may require other changes, the Contracting Department shall forward the Contracted Provider's written notification to the Provider Relations Department, as appropriate, for processing. The Contracting Department shall notify the Contracted Provider of the results of the review via e-mail and shall include the appropriate CalOptima Health department's contact information for the Contracted Provider to follow up.~~

b. ~~To effectuate the Contracted Provider's~~ If the Provider disagrees with the termination, the Provider may appeal this decision in accordance with the CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint.

F. Changes, Post Contract Modifications

~~2.~~1. CalOptima Health shall ensure that contractual ~~change(s)~~changes submitted by the Provider are implemented across ~~all~~ applicable operational ~~CalOptima Health~~ departments. To facilitate this, the Contracting Department shall ~~send~~distribute the executed contract~~/~~, amendment, Assignment Agreement, or termination notice to the ~~following~~ departments~~:~~ listed below:

a. Behavioral Health Integration;

b. Claims Administration

~~b.~~c. Enterprise Project Management Office;

~~c. Claims Administration;~~

d. Finance;

e. Information Technology Services (ITS);

f. Long Term Services and Supports;

For 2025 1204 BOD Review Only

g. Pharmacy Management;

h. Program of All-Inclusive Care for the Elderly (PACE);

i. Provider Data ~~Management Services (PDMS~~Operations (PDO);

j. Provider Relations;

k. Quality Improvement;

l. Regulatory Affairs & Compliance (RAC); and

m. Utilization Management.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
B. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
C. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
D. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Supersedes APL 16-001)
~~C.~~E. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/22/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
02/03/2022	Regular Meeting of the CalOptima Board of Directors
12/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/03/2022	EE.1116	Contracted Provider Notification to CalOptima of Changes Affecting the Legal Status of the Contract	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	EE.1116	Contracted Provider Notification to CalOptima Health of Changes Affecting the Legal Status of the Contract	Medi-Cal OneCare PACE

For 12/04 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2023	EE.1116	Contracted Provider Notification to CalOptima Health of Changes Affecting the Legal Status of the Contract	Medi-Cal OneCare PACE
Revised	11/01/2024	EE.1116	Contracted Provider Notification to CalOptima Health of Changes Affecting the Legal Status of the Contract	Medi-Cal OneCare PACE
Revised	12/01/2025	EE.1116	Contracted Provider Notification to CalOptima Health of Changes Affecting the Legal Status of the Contract	Medi-Cal OneCare PACE

For 20251204 BOD Review Only

IX. GLOSSARY

Term	Definition
Assignment Agreement	An agreement that transfers the obligations and responsibilities under a contract from the current owner to the new owner.
Change of Ownership	For purposes of this policy, a change of ownership is when there is a change of: 1. More than 25% of the ownership or equity interest in Provider; 2. More than 25% of the directors or trustees of Provider; 3. The merger, re-organization, or consolidation of Provider with another entity, with respect to which Provider is not the surviving entity; and/or 4. A change in management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (i.e., the Board of Directors) to a third-party management person, company, group, team or other entity.
Contracted Provider	For the purposes of this policy, a Contracted Provider includes but is not limited to a professional, behavioral health, ancillary, CBAS, hospital, long term care facility/skilled nursing facility, pharmacy, or Health Network that is contracted with CalOptima Health (via Fee-for-Service contract or capitated Delegated Entity contract) to provide covered services to CalOptima Health Members for one or more CalOptima Health program.
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~~)~~, Subcontractor, or First Tier Entity that contracts with CalOptima Health to provide Covered Services to Members ~~assigned to that Health Network~~.
Member	~~A beneficiary~~An individual enrolled in a CalOptima Health program.
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 PCP may be a Primary Care Physician or Non-Physician Medical Practitioner.
Program	Any of CalOptima Health's programs, including the CalOptima Health Medi-Cal Program, OneCare, PACE, or the Multipurpose Senior Service Program.
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.

For 2025120H BOD Preview Only

Policy:	EE.1116
Title:	**Contracted Provider Notification to CalOptima Health of Changes Affecting the Legal Status of the Contract**
Department:	Contracting
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	02/03/2022
Revised Date:	12/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 20251204 ROD Review Only

I. PURPOSE

This policy establishes the process and outlines the requirements for Contracted Providers to notify CalOptima Health of any changes affecting their legal status, in compliance with both state and federal regulations.

II. POLICY

A. CalOptima Health requires all contracted Providers to promptly report any changes to their contract, in accordance with our contract with the Department of Health Care Services (DHCS) and All Plan Letters (APLs).

B. CalOptima Health requires Contracted Providers to submit a written notification to the Contracting Department, in accordance with the terms of their contract, for changes that may impact their contract. Such changes include, but are not limited to:

1. Changes to National Provider Identifier (NPI) and/or Tax Identification Number (TIN);
2. Changes to ownership, directors, or trustees;
3. Changes to Contracted Provider's legal or "doing business as" (dba) name;
4. Changes to availability or location of services (i.e., closure of company or location(s) that are listed in Provider's contract; new location);
5. Changes to Notice Address; and
6. Changes to staffing due to the retirement or death of a professional with an individual contract.

III. PROCEDURE

A. Preliminary Evaluation

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1. The Contracting Department receives notice from a Provider regarding changes to their legal status.

    a. Upon receipt of Provider's notice, the Contracting Department shall:

        i. Provide confirmation to the Provider that includes the receipt date, expected review time, and any additional information that may be needed.

        ii. Identify applicable revisions to their legal status, for example, initiating a new contract, assignment agreement, issuing a contract amendment, proceeding with a contract termination, or confirming that no contractual action is required.

        iii. Identify operational impacts to the organization.

            a) Impacts Network Adequacy: The Contracting Department will attempt to recruit for additional providers;

            b) Impacts Internal Departments: The Contracting Department will coordinate with Delegation Oversight, Quality Improvement, or Medical Management, and obtain such approval; and

            c) Impacts Network Operations: The Contracting Department will assess if Board of Directors (BOD) action is required. The Contracting Department will consult with legal counsel and other relevant departments as applicable, submit a CalOptima Health Board Action Agenda Referral (COBAR), and seek BOD approval.

B. Changes That Require a New Contract

1. The Contracting Department shall initiate a new contract when there is a new legal entity (i.e., new NPI, tax ID). These changes signify a material change in the Provider's legal identity and therefore require a new contract to ensure compliance with CalOptima Health's contracting standards. The new contract shall be executed in accordance with CalOptima Health Policies, EE.1141: CalOptima Health Provider Contracts and GG.1650: Credentialing and Recredentialing of Practitioners.

    a. The Contracting Department shall make best efforts to align the termination date of the Provider's existing contract to that of the effective date of the Provider's new contract to ensure continuity when applicable.

C. Changes That Require an Amendment

1. The Contracting Department shall initiate an amendment to the Provider's contract when changes are not related to the legal entity, such as updates to the ownership, directors, or trustees, to the Provider's Notice Address, or the addition or removal of service locations.

D. Changes That Require an Assignment and Assumption

1. The Contracting Department shall initiate an Assignment and Assumption to transfer of contractual rights and obligations from a selling Provider to an acquiring Provider. contract.

    a. The acquiring Provider must meet the credentialing requirements in accordance with CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners.

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E. Changes That Require a Contract Termination

1. The Contracting Department shall initiate a termination due to the retirement or death of a professional with a solo contract, a request to assign is declined or the Provider is relocating out of CalOptima Health's service area.

   a. The termination is processed in accordance with the terms of the contract and CalOptima Health policies and DHCS APL 21-003: Medi-Cal Network Provider and Subcontractor Terminations. This process includes a formal termination letter that references the applicable provision in the provider contract.

   b. If the Provider disagrees with the termination, the Provider may appeal this decision in accordance with the CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint.

F. Changes, Post Contract Modifications

1. CalOptima Health shall ensure that contractual changes submitted by the Provider are implemented across applicable operational departments. To facilitate this, the Contracting Department shall distribute the executed contract, amendment, Assignment Agreement, or termination notice to the departments listed below:

   a. Behavioral Health Integration;

   b. Claims Administration

   c. Enterprise Project Management Office;

   d. Finance;

   e. Information Technology Services (ITS);

   f. Long Term Services and Supports;

   g. Pharmacy Management;

   h. Program of All-Inclusive Care for the Elderly (PACE);

   i. Provider Data Operations (PDO);

   j. Provider Relations;

   k. Quality Improvement;

   l. Regulatory Affairs & Compliance (RAC); and

   m. Utilization Management.

IV. ATTACHMENT(S)

Not Applicable

For 20251204 BOD Review Only

V. REFERENCE(S)

A. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
B. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
C. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
D. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Supersedes APL 16-001)
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/22/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
02/03/2022	Regular Meeting of the CalOptima Board of Directors
12/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/03/2022	EE.1116	Contracted Provider Notification to CalOptima of Changes Affecting the Legal Status of the Contract	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	EE.1116	Contracted Provider Notification to CalOptima Health of Changes Affecting the Legal Status of the Contract	Medi-Cal OneCare PACE
Revised	12/01/2023	EE.1116	Contracted Provider Notification to CalOptima Health of Changes Affecting the Legal Status of the Contract	Medi-Cal OneCare PACE
Revised	11/01/2024	EE.1116	Contracted Provider Notification to CalOptima Health of Changes Affecting the Legal Status of the Contract	Medi-Cal OneCare PACE
Revised	12/01/2025	EE.1116	Contracted Provider Notification to CalOptima Health of Changes Affecting the Legal Status of the Contract	Medi-Cal OneCare PACE

For Review Only

IX. GLOSSARY

Term	Definition
Assignment Agreement	An agreement that transfers the obligations and responsibilities under a contract from the current owner to the new owner.
Change of Ownership	For purposes of this policy, a change of ownership is when there is a change of: 1. More than 25% of the ownership or equity interest in Provider; 2. More than 25% of the directors or trustees of Provider; 3. The merger, re-organization, or consolidation of Provider with another entity, with respect to which Provider is not the surviving entity; and/or 4. A change in management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (i.e., the Board of Directors) to a third-party management person, company, group, team or other entity.
Contracted Provider	For the purposes of this policy, a Contracted Provider includes but is not limited to a professional, behavioral health, ancillary, CBAS, hospital, long term care facility/skilled nursing facility, pharmacy, or Health Network that is contracted with CalOptima Health (via Fee-for-Service contract or capitated Delegated Entity contract) to provide covered services to CalOptima Health Members for one or more CalOptima Health program.
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), Subcontractor, or First Tier Entity that contracts with CalOptima Health to provide Covered Services to Members.
Member	An individual enrolled in a CalOptima Health program.
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 PCP may be a Primary Care Physician or Non-Physician Medical Practitioner.
Program	Any of CalOptima Health's programs, including the CalOptima Health Medi-Cal Program, OneCare, PACE, or the Multipurpose Senior Service Program.
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.

For 20251204 BOD Preview Only

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 4, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

13. Approve the CalOptima Health Measurement Year 2026 Medi-Cal and OneCare Pay for Value Programs and Measurement Year 2027 Covered California Pay for Value Program

Contact

Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Actions

1. Approve CalOptima Health Measurement Year 2026 Medi-Cal Delegated Health Network Pay for Value Performance Program effective January 1, 2026, through December 31, 2026.
2. Approve CalOptima Health Measurement Year 2026 OneCare Delegated Health Network Pay for Value Performance Program effective January 1, 2026, through December 31, 2026.
3. Approve CalOptima Health Measurement Year 2027 Covered California Health Network Pay for Value Performance Program effective January 1, 2027, through December 31, 2027.
4. Approve Measurement Year 2026 Medi-Cal and OneCare Primary Care Provider Pay for Value Performance Programs, one-time provider incentives for digital technology improvements and utilization of physician incentive software to provide a real-time, point-of-care approach that rewards physicians for the completion of specific value-based care actions.

Background

CalOptima Health's Pay for Value Performance Program (P4V Program) recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health Networks (HNs), CalOptima Health Community Network (CHCN), and HN's primary care physicians (PCPs), are eligible to participate in the P4V Program.

The purpose of CalOptima Health's P4V Program is to:

1. Recognize and reward HNs and CHCN PCPs for demonstrating quality performance;
2. Drive improvement in quality outcomes and processes through monetary incentives and penalties;
3. Provide comparative performance information for members, providers, and the public on CalOptima Health's HN and CHCN PCP performance; and
4. Provide industry benchmarks and data-driven feedback to HNs and CHCN PCPs on their quality improvement efforts.

CalOptima Health staff have obtained feedback from HN and CHCN physician partners on recommendations to refine and improve the P4V Program to drive improvement and achieve quality goals. Feedback includes increasing incentive amounts, phasing-in programmatic changes, and shifting from a retrospective pay for performance model to a real-time, point-of-care approach that rewards physicians, and potentially physician staff, for the completion of specific value-based care actions.

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These recommendations are incorporated into the Calendar Year 2026 program elements discussed below.

Discussion

Measurement Process

CalOptima Health staff calculates the quality rating score for each HN annually. For Measurement Year (MY) 2026, staff will use the Integrated Healthcare Association (IHA) methodology for both Medi-Cal and OneCare. This will enable CalOptima Health to use an industry standard methodology and improve efficiencies by using one standard quality rating methodology. The performance score is derived from the most recently available audited Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Centers for Medicare & Medicaid Services (CMS) Star measure data. The Covered California P4V Program will be based on comparison to benchmarks only since prior year rates will not be available.

Medi-Cal Delegated Health Network P4V Program

Staff recommends implementing MY 2026 Delegated Health Network Medi-Cal P4V Program with the following program components:

1. Maintain IHA pay for performance methodology to assess performance.
    - The methodology uses both attainment and improvement to assess performance and is based on the CMS hospital value-based purchasing model.
    - The greater of either the attainment or improvement score will be used to calculate incentive payments.
    - A total quality score will be calculated based on the sum of points earned for each measure on a scale of 0 to 10, with 10 as the maximum.
        - The total quality score determines the percentage of incentive pool earned with the total rating equating to the percentage of incentive allocation earned. For example, a quality rating of 3.5 equates to 35% of the incentive allocation.

2. Utilize the MY 2026 Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures held to minimum performance level (MPL) for the HEDIS measurement set. Based on preliminary notice from DHCS, the MY 2026 Medi-Cal P4V Program will have a total of 20 quality measures. CalOptima Health's P4V Program will adopt the final MY 2026 MCAS MPL measure set upon availability by DHCS.

3. Continue to include CAHPS composites and overall ratings as member experience measures. Utilize both the child and adult CAHPS results, proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.

4. Continue to use the National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles as benchmarks. For MY 2026, MY 2025 Medicaid percentiles

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will be used as benchmarks.

5. Maintain program funding methodology at 10% of professional capitation (base rate only).

6. Corrective Action:
   HNs that score below the 50th percentile will be required to submit an improvement plan for that measure to CalOptima Health.

7. Application of DHCS Quality Withhold:
   DHCS will maintain its quality withhold and incentive program for managed care plans. For calendar year 2026, the quality withhold percent will remain 1.0% of capitation payments from each Medi-Cal managed care plan. DHCS may apply a higher withhold percentage in future Medi-Cal managed care plan contracts.

   Based on the DHCS quality measures, CalOptima Health will be assessed for the amount of withhold payments that may be earned back. The unearned percentage will be applied in CalOptima Health's P4V calculation across all HNs. Staff recommends deducting the percent of unearned DHCS withhold from each HN's earned P4V Program payment.

8. Utilize unearned incentive dollars for quality improvement initiatives in the form of grants to HNs or for CalOptima Health-led initiatives such as the member health reward program, mobile or at-home health screenings, digital measure improvements, etc.

OneCare Delegated Health Network P4V Program
Staff recommends implementing MY 2026 OneCare P4V Program with the following program components:

1. Adopt the IHA pay for performance methodology, as described in the Medi-Cal section above, to assess performance. Performance will be calculated on a Star rating scale based on CMS Star ratings. The percentage of OneCare incentive earned will be determined as follows:

OneCare P4V Performance	MY2026 Incentive Percent SY2028
Below 3.0 stars	0%
3 Stars	20%
3.5 Stars	40%
4.0 Stars	60%
4.5 Stars	80%
5.0 Stars	100%

Note: MY = measurement year, SY= Star rating display year

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2. Utilize select CMS Part C and D measures for the P4V measurement set. Selected measures are those that are directly aligned with HN responsibilities.

3. Utilize CMS Star cut-points as benchmarks. For MY 2026, the 2028 Star Rating cut points will be used.

4. Maintain program funding at $20 per member per month (PMPM).

~~5.~~ HNs that score below the 3-Stars will be required to submit an improvement plan for that measure to CalOptima Health.

6. Utilize unearned incentive dollars for quality improvement initiatives in the form of grants to HNs or for CalOptima Health-led initiatives.

Covered California Health Network P4V Program

Covered California values continuous improvement in the quality of care provided to its enrollees. To encourage quality improvement, Covered California maintains a Quality Transformation Initiative (QTI) program to provide financial incentives to Qualified Health Plans (QHP) participating in Covered California. Performance measures in QTI are based on CMS Quality Rating System (QRS) and NCQA HEDIS measures.

Staff recommends initiating a MY 2027 HN Covered California P4V Program with the following program components:

1. Adopt the Covered California QTI performance measures. For MY 2027, the calendar year 2027 QTI measures will be used.
2. Utilize NCQA Quality Compass National Exchange (NCQA Exchange) percentiles as benchmarks. For MY 2027, the MY 2026 NCQA Exchange percentiles will be used.
3. Performance will be assessed by comparing HN measure rates to the NQCA Exchange percentiles as follows:

NCQA Quality Compass National Exchange Percentile	% of Incentive Earned per Measure
75th	100%
66th	75%
50th	50%
33rd	25%

4. Fund the Covered California P4V Program at 10% of professional capitation (base rate only).

MY 2026 CalOptima Health Community Network Medi-Cal and OneCare Primary Care Provider P4V Programs and One-time Provider Incentives for Digital Technology Improvements

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Staff recommends moving from an annual, retrospective physician pay for performance model to a real-time approach for HN and CHCN PCPs to achieve:

1. **Timely Feedback:** Real-time data will allow physicians to receive immediate feedback on their performance. This can help them quickly identify areas needing improvement and make necessary adjustments, leading to better patient outcomes and an overall improvement in CalOptima Health's quality performance.

2. **Continuous Improvement:** With real-time monitoring, physicians can continuously track their performance against quality measures. This ongoing process encourages a culture of continuous improvement rather than waiting for an annual review.

3. **Enhanced Patient Care:** Real-time data can highlight care gaps as they occur, enabling physicians to address these issues promptly. This proactive approach can lead to more timely interventions and better overall patient care.

4. **Increased Engagement:** Physicians are more likely to be engaged and motivated when they can see the immediate impact of their actions.

5. **Reduced Administrative Burden:** Annual reviews often require significant administrative work to compile and analyze data. A real-time approach can streamline this process, reducing the administrative burden on staff.

Staff recommends utilizing a software vendor to deliver the PCP P4V Program. The physician incentive software will be used by CalOptima Health contracted providers to view and close quality care gaps and earn corresponding P4V incentive dollars. The physician incentive software will:

1. Provide a single view of health-promoting behaviors and corresponding incentive values (*e.g.*, complete breast cancer screening) through a simple user interface that engages PCPs and office staff.

2. Support real-time updates to care gap closure status upon the physician/office staff taking action.

3. Ensure timely and transparent incentive payments to providers, providing payments throughout the year versus annually.

4. Support the ability to share rewards across physician office staff to engage all levels of the provider practice/clinic.

PCPs can earn incentives for implementing processes to close care gaps and for providing services to close care gaps, including the following activities:

- Calling members to schedule an appointment;
- Referring members for services such as mammograms, retinal eye exams, colonoscopy, etc.;

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- Ordering laboratory tests;
- Reviewing test results with members;
- Conducting medication review; and
- Providing preventive services (*i.e.*, annual wellness visits, assessments, etc.).

Providers will have visibility to their member panel with care gaps, actions that can earn incentives, and their progress made toward earning incentives as actions are taken and care gaps are closed. Incentives will range from $5 to $50 depending on the action taken and care gap closed.

One-time Provider Incentives for Digital Technology Improvements: This program will also include one-time incentives of $1,000 per type per provider for adopting the following digital technology improvements:

- Conversion from paper checks to electronic fund transfer.
- Provider portal adoption.
- Provider electronic medical record adoption.

Staff will initiate the PCP P4V Program with OneCare and add Medi-Cal after an initial pilot period during Quarter 1 of 2026. Funding for this program and the one-time incentives to support provider adoption of digital technology improvements will draw from MY 2024 unearned P4V funds.

MY 2026 Unearned Incentive Dollars
MY 2026 P4V funds that remain unused – due to HNs failing to earn the maximum incentive possible or due to forfeitures based on CalOptima Health's failure to achieve the MPL – may be used for quality improvement initiatives. Grants will be available from unearned funds for both Medi-Cal and OneCare.

HNs may apply for grants to utilize incentive dollars for quality improvement initiatives. Grants may be awarded for individual measures or groups of measures targeting similar member populations, for example, well-child visits and childhood immunizations. Total grant funds to an individual HN will not exceed the HN's maximum pool funding incentive for each MY, including deduction for DHCS quality withholds. Grants may not be used to fund administrative staffing nor for capital investments but may be used for staff for direct implementation of quality initiatives.

Staff will provide oversight of grants pursuant to CalOptima Health Policy AA.1400: Grants Management and will return to the Board to provide updates on the status of these grants at future meetings.

CalOptima Health will utilize a portion of the unearned HN P4V funds for the MY 2026 PCP P4V programs and for CalOptima Heath quality improvement initiatives such as member outreach and education, programs to close care gaps, and programs to close data gaps.

Unearned incentive funds will be used as described herein. Staff will finalize expenditures from the

MY 2026 P4V programs by Quarter 4 of 2028 and report back to the Board of Directors.

Eligibility for Incentive Payments
Performance incentive payments are distributed upon final calculation and validation of each measurement rate. To qualify for payments, a HN must be contracted with CalOptima Health during the entire measurement period (January 1, 2026, through December 31, 2026), the calculation period (January 1, 2027, through December 30, 2027), and at the time of disbursement of payment. HNs and PCPs must also be in good standing with CalOptima Health at the time of disbursement of payment. Good standing includes the provider having an active contract, including contract amendments; being free of contract sanctions and limitations; and not having substantive corrective action, as determined by the Audit and Oversight department. HNs must distribute a minimum of 85% of their incentive payment to their contracted physicians.

Fiscal Impact

Medi-Cal P4V Program
Staff estimates that the fiscal impact for the MY 2026 P4V Program will be no more than 10% of the professional capitation (base rate only) or approximately $73.9 million. Staff will include estimated pool funding for the MY 2026 P4V Program initiatives and grant activities in the Fiscal Year (FY) 2026-27 Operating Budget.

OneCare P4V Program
Staff estimates that the fiscal impact for the MY 2026 OneCare P4V Program will be no more than $20 PMPM or approximately $4.3 million. Staff will include estimated pool funding for the MY 2026 P4V Program initiatives and grant activities in the FY 2026-27 Operating Budget.

Covered California P4V Program
Staff estimates that the fiscal impact for the MY 2027 Covered California P4V Program will be no more than 10% of the final professional capitation. Staff will include estimated pool funding for the MY 2027 Covered California P4V Program initiatives in future operating budgets.

MY2026 CalOptima Health Community Network Medi-Cal and OneCare PCP P4V Programs and One-time Provider Incentives for Digital Technology Improvements
Staff estimates that the fiscal impact for the MY 2026 Medi-Cal PCP P4V Program will not exceed $10.0 million, and the OneCare PCP P4V Program will not exceed $1.0 million. The fiscal impact for the one-time incentives to support provider adoption of digital technology improvements is estimated at $6.0 million for Medi-Cal and $1.0 million for OneCare. Staff anticipates that the estimated remaining balances in unearned funds from the MY 2024 Medi-Cal and OneCare P4V Programs will be sufficient to fund these initiatives.

Rationale for Recommendation

CalOptima Health strives to continuously improve the quality of care and outcomes for all members. CalOptima Health is committed to demonstrating breakthrough improvement in quality measures, achieving high performing managed care plan status and achieving a 5-Star rating status. To achieve

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optimal quality performance and more fully engage the physician network, it is critical that CalOptima Health shift from a retrospective P4V model to a real-time, point-of-care approach that rewards physicians for the completion of specific value-based care actions.

Concurrence

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

Attachments

1. CalOptima Health Measurement Year 2026 Pay for Value Programs
2. Measurement Year 2026 Pay for Value Programs and Measurement Year 2027 Covered California Pay for Value Program Presentation

/s/ Michael Hunn *11/25/2025*
Authorized Signature **Date**

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Attachment 1

CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs and MY 2027 Covered California Pay for Value Program

MY 2026 Medi-Cal Pay for Value (P4V)

The Medi-Cal P4V program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) that are included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V programs also includes incentives for Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. Health networks (HNs) and CalOptima Health primary care providers are eligible to participate in the Medi-Cal P4V program.

MY 2026 Medi-Cal P4V Program Components

1. Include measures held to a DHCS MPL or quality withhold in the MY2026 MCAS measure set.

MY 2026 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness- 30 days	Prenatal and Postpartum Care: Postpartum Care
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Depression Screening and Follow-Up for Adolescents and Adults	Postpartum Depression Screening and Follow Up
Child and Adolescent Well-Care Visits	Prenatal Depression Screening and Follow Up
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Development Screening in the First Three Years of Life*	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	Colorectal Cancer Screening
Lead Screening in Children	CAHPS- Rating of Health Network: Adult and Child
Topical Fluoride in Children*	CAHPS- Rating of Health Care: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Controlling High Blood Pressure	CAHPS- Getting Needed Care: Adult and Child
Glycemic Status Assessment for Patients with Diabetes (>9%)	CAHPS- Getting Care Quickly: Adult and Child
	CAHPS- Coordination of Care: Adult and Child

   - Utilize both Child and Adult CAHPS scores proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.
2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
   - Attainment and Improvement scores are calculated for each measure. The better of the two scores is used.
   - Scoring
     - Attainment Points

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- Scale of 1-10 points
- Points based on performance between 50th percentile and 95th percentile.
- $1 + \left(\frac{(MY2026\ Rate - 50th\ Percentile)}{((95th\ Percentile - 50th\ Percentile)/9)} \right)$

▪ Improvement Points
- Scale of 0-10 points
- Points reflect performance in the prior year compared to the current year.
- $\left(\frac{(MY2026\ Rate - MY2025\ Rate)}{((95th\ Percentile - MY2025\ Rate)/10)} \right)$

3. Prior year (MY2025) National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks. *Developmental Screening in the First Three Years of Life and Topical Fluoride are CMS measures where the only benchmark is the 50th percentile. For these two measures, CMS percentiles will be used and HNs will earn 10 points for performance at or above the 50th percentile and 1 point for performance below the 50th percentile.
4. Measure weighting
   - HEDIS measures weighted 1.0
   - CAHPS measures weighted 1.5
5. Maintain program funding at ten percent (10%) of professional capitation (base rate only).
6. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance.
7. HNs that score below the 50th percentile will be required to submit an improvement plan for that measure to CalOptima Health.
8. DHCS quality withhold penalties will be deducted from each HN's earned P4V program payment.

Attachment 1

CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs and MY 2027 Covered California Pay for Value Program

OneCare Pay for Value Program (P4V)

The OneCare P4V program focuses on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Health networks (HNs) and CalOptima Health primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.

MY 2026 OneCare P4V Program Components

Alignment with the CMS Star program and the following components- CMS Star Part C and Part D measures, measure weights, and Star cut points as benchmarks:

1. Utilize a subset of CMS Star measures

MY 2026 OneCare Pay for Value Program Measurement Set	
Measure Category	**Measure**
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Care for Older Adults- Medication Review
	Care for Older Adults- Functional Status Assessment
	Osteoporosis Management in Women who had a Fracture
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – Blood Sugar Controlled
	Kidney Health Evaluation for Patients with Diabetes
	Controlling Blood Pressure
	Transitions of Care
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
	Statin Therapy for Patients with Cardiovascular Disease
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Network Quality
	Rating of Health Network
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Concurrent Use of Opioids and Benzodiazepines

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

   - Scoring

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- Attainment Points
  - Scale of 1-5 points
  - Points based on performance between 3-Star and 5-Star cut points.
  - $1 + \left(\frac{(MY2026\ Rate - 3\ Star\ cut\ point)}{((5\ Star\ cut\ point - 3\ Star\ cut\ point)/4)} \right)$
- Improvement Points
  - Scale of 0-5 points
  - Points reflect performance in the prior year compared to the current year.
  - $\left(\frac{(MY2026\ Rate - MY2025\ Rate)}{((5\ Star\ cut\ point - MY2025\ Rate)/5)} \right)$

3. MY2026 CMS Star cut points used as benchmarks. These benchmarks will be released by CMS in Q4 2027 in the 2028 Star Rating Technical Notes.
4. Measure weighting
   - HEDIS process measures weighted 1
   - CAHPS measures weighted 2
   - Outcome measures weighted 3
5. Apply a program funding methodology of $20 PMPM
6. Available Incentive Pool: the OneCare incentive pool will be determined by each HN's Stars performance as described in the table below. Actual OneCareP4V incentives will be based on performance as described in this section.

OneCare P4V Performance	MY2026 Incentive Percentage **SY2028**
Below 3.0 stars	0%
3 Stars	20%
3.5 Stars	40%
4.0 Stars	60%
4.5 Stars	80%
5.0 Stars	100%

Note: MY = measurement year, SY= Star rating display year

7. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance
8. HNs that score below 3.0 Stars will be required to submit an improvement plan for that measure to CalOptima Health.

Attachment 1

CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs and MY 2027 Covered California Pay for Value Program

Covered California Pay for Value Program (P4V)

The Covered California P4V program focuses on measures included in the Quality Transformation Initiative. Health networks (HNs) are eligible to participate in the Covered CA P4V program.

MY 2027 Covered CA P4V Program Components

Alignment with the Covered CA Quality Transformation Initiative (QTI) and the following components:

1. CalOptima Health will adopt the 2027 QTI measures for the MY2027 P4V Program.

MY 2027 Covered CA Pay for Value Program Measurement Set
Controlling High Blood Pressure
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
Colorectal Cancer Screening
Childhood Immunization Status (Combo 10)
Depression Screening and Follow-Up for Adolescents and Adults

2. Utilize an attainment scoring methodology where rates that meet designated benchmarks qualify for percentages of incentives per measure
3. MY2026 National Committee for Quality Assurance (NCQA) Quality Compass National Exchange percentiles used as benchmarks
4. Measures will be weighted equally
5. Establish program funding at ten percent (10%) of professional capitation (base rate only)
6. Covered CA P4V incentives will be based on performance compared to benchmarks as described below:

NCQA Quality Compass National Exchange Percentile	% of Incentive Earned per Measure
75th	100%
66th	75%
50th	50%
33rd	25%

7. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance

Measurement Year (MY) 2026 Pay for Value Program

Special Quality Assurance Committee Meeting

November 13, 2025

Linda Lee, Executive Director Quality Improvement

Our Mission

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

Our Vision

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

Background

- CalOptima Health has implemented a Pay for Value Program (P4V) to reward high performing Health Networks
- CalOptima Health's P4V program has historically provided upside incentives and no downside penalties
- The P4V program has resulted in mixed performance across products and at the Health Network level

MY2026 Delegated Health Network P4V Program Components

MY2026 P4V Program Elements

- Measure Sets
  - Medi-Cal: Align with DHCS MCAS MPL and Quality Withhold measures
    - Utilize HEDIS and DHCS clinical measures
    - Utilize both Child and Adult CAHPS rates
  - OneCare: Align with CMS Star measures most impactable by HNs
    - Utilize Part C HEDIS and CAHPS measures
    - Utilize Part D measures

MY2026 P4V Program Elements

- Measure Weights
  - Align with industry measure weights, where applicable
  - Clinical measures = 1.0
  - Medi-Cal Member experience measures = 1.5
  - OneCare Member experience measures = 2.0
- Data Collection Methodology
  - To promote adoption of electronic clinical data sets, utilize administrative data

Performance Methodology and Benchmarks

- Adopt Integrated Healthcare Association (IHA) scoring method
  1. Performance points are calculated by comparing HN score to benchmarks, starting at the 50th percentile for Medi-Cal and 3-Stars for OneCare
  2. Performance points are also calculated by comparing a HN's prior year score to current score
- Use option 1 or 2, selecting option with higher number of points
- Medi-Cal
  - Based on NCQA National Medicaid Percentiles
- OneCare
  - Based on CMS Star cut points

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Medi-Cal P4V Incentive Percentages

- A total quality score is calculated based on the sum of points earned for each measure on a scale of 0 to 10, with 10 as the maximum.
- The total quality score determines the percentage of incentive pool earned with the total rating equating to the percentage of incentive allocation earned.
  - For example, a quality rating of 3.5 equates to 35% of the incentive allocation

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OneCare P4V Incentive Percentages

OneCare P4V Performance	MY2026 Incentive Percent SY2028
Below 3.0 stars	0%
3 Stars	20%
3.5 Stars	40%
4.0 Stars	60%
4.5 Stars	80%
5.0 Stars	100%

Health Network Corrective Action

- Corrective action: HN scoring below the MPL on Medi-Cal or below 3.0 Stars on Medicare must submit a corrective action plan

Additional Health Network Penalties

- CalOptima Health will pass down any impact of the DHCS quality withhold program
  - For MY2026, the withhold is 1.0% of capitation
  - Any unearned withhold will be deducted from each HN's PV4 program payment

MY2026 Incentive Pool

- Medi-Cal:
  - Ten percent of professional capitation (base rate only)
  - Estimated at $73 million

- OneCare:
  - $20pmpm
  - Estimated at $4.3 million

Unearned Incentive Dollars

- Issue quality grants using unearned dollars
- Grants will be used to improve individual or groups of measures
- Funds used for quality improvement efforts including staff directly involved with quality initiatives
- HNs submit a plan, subject to quarterly monitoring
  - Must meet implementation requirements to continue to access improvement funds
- CalOptima Health will implement delivery system-wide interventions

MY2027 Covered CA P4V Program

MY2027 Covered CA Program Components

- Utilized Covered CA Quality Transformation Initiative (QTI) measure set
- Measures will be equally weighted
- Utilize NCQA Exchange National Percentiles as benchmarks
- Performance assessed on attainment of benchmarks
  - P4V program budgeted at ten percent of professional capitation (base rate only)

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MY2027 Covered CA P4V Incentive Percentages

NCQA Quality Compass National Exchange Percentile	% of Incentive Earned per Measure
75th	100%
66th	75%
50th	50%
33rd	25%

MY2026 Primary Care Provider P4V Program Components

Primary Care Provider P4V

- Carve-out a portion of Health Network P4V for primary care provider (PCP) incentives from unearned incentives to drive improvement at the point of care
- CalOptima Health issued an RFP in August 2025 to acquire a vendor to implement this program
- PCPs can earn incentives for implementing processes to close care gaps and for providing services to close care gaps
  - Call members to schedule an appointment
  - Refer members for services
  - Review results with members
  - Provide services i.e. annual wellness visits, assessments, etc.

One-Time Provider Incentives for Digital Technology Improvements

- Conversion from paper checks to electronic fund transfer
  - One-time incentive of $1000 per provider
- Provider Portal adoption
  - One-time incentive of $1000 per provider
- Provider EMR adoption
  - One-time incentive of $1000 per provider

CalOptima Health Investments

- CalOptima Health is in the process of implementing Cozeva PayerOne
  - Direct access to provider EMR
  - Provides a data system for providers to update care gap closure
  - Provides a data system for providers to submit supplemental data

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APPENDIX

MY2026 Medi-Cal P4V Measurement Set

MY 2026 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness- 30 days	Prenatal and Postpartum Care: Postpartum Care
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Depression Screening and Follow-Up for Adolescents and Adults	Postpartum Depression Screening and Follow Up
Child and Adolescent Well-Care Visits	Prenatal Depression Screening and Follow Up
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Development Screening in the First Three Years of Life*	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	Colorectal Cancer Screening

MY2026 Medi-Cal P4V Measurement Set

MY 2026 Medi-Cal Pay for Value Program Measurement Set	
Lead Screening in Children	CAHPS- Rating of Health Network: Adult and Child
Topical Fluoride in Children*	CAHPS- Rating of Health Care: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Controlling High Blood Pressure	CAHPS- Getting Needed Care: Adult and Child
Glycemic Status Assessment for Patients with Diabetes (>9%)	CAHPS- Getting Care Quickly: Adult and Child
	CAHPS- Coordination of Care: Adult and Child

MY2026 OneCare P4V Measurement Set

MY 2026 OneCare Pay for Value Program Measurement Set	
Measure Category	Measure
Part C	Breast Cancer Screening
HEDIS	Colorectal Cancer Screening
	Care for Older Adults- Medication Review
	Care for Older Adults- Functional Status Assessment
	Osteoporosis Management in Women who had a Fracture
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – Blood Sugar Controlled
	Kidney Health Evaluation for Patients with Diabetes
	Controlling Blood Pressure
	Transitions of Care
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
	Statin Therapy for Patients with Cardiovascular Disease

MY2026 OneCare P4V Measurement Set

MY 2026 OneCare Pay for Value Program Measurement Set	
Measure Category	Measure
Part C	Care Coordination
Member Experience	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Network Quality
	Rating of Health Network
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Concurrent Use of Opioids and Benzodiazepines

MY2027 Covered CA P4V Measurement Set

MY 2027 Covered CA Pay for Value Program Measurement Set
Controlling High Blood Pressure
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
Colorectal Cancer Screening
Childhood Immunization Status (Combo 10)
Depression Screening and Follow-Up for Adolescents and Adults

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 4, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

14. Approve Material Change to Grant Award Agreement with Coalition of Orange County Community Health Centers for Population Health and Value-Based Care Transformation

Contacts

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

Recommended Action

Approve a material change to the Population Health and Value-Based Care Transformation Grant with the Coalition of Orange County Community Health Centers to increase the Year Four budget.

Background

On April 7, 2022, the CalOptima Health Board of Directors (Board) authorized the Chief Executive Officer (CEO) to launch a five (5)-year, $50 million initiative with community health centers to enhance access, quality, and further strengthen the safety net system across Orange County. The Board appropriated up to $50 million from existing reserves to fund this effort. The Board also authorized the CEO to execute a grant agreement with Coalition of Orange County Community Health Centers (Coalition) to implement this initiative, with the specific aims to:

1. Enhance and strengthen primary care safety net quality infrastructure;
2. Enhance and strengthen safety net primary care delivery systems; and
3. Enhance and strengthen processes to support the goals of high value care.

CalOptima Health and the Coalition entered into a grant agreement on July 1, 2022, (Agreement) under which CalOptima Health provided up to $10 million per year for five (5) years, totaling a maximum of $50 million, to the Coalition to implement its proposed Population Health and Value-Based Care Transformation (PHVBC) initiative. The Agreement is set to terminate on March 31, 2028, or upon completion of the project, whichever occurs last.

Based on progress reports from the Coalition, the first three years of the PHVBC initiative—consisting of one year of planning and two years of implementation—have focused on building the foundational systems, service lines, and supports necessary to strengthen participating health centers' capacity for population health management. Health center teams were given flexibility to identify the change ideas and priority areas most relevant to their patient populations and clinic contexts. They were expected to pilot these system enhancements and track progress using both outcome and process/intervention measures. In Year 3 of the grant program (health centers' second year of implementation work), participating health centers continued to refine and deepen their work.

In August 2025, the Board ratified an amendment to the Agreement that included the following changes:

- CalOptima Health will apply unearned funds from Years 1 and 2 to offset expenditures in Year 3;
- New provisions were added regarding unauthorized use of funds, compliance with laws and policies, conflicts of interest, reports, monitoring, certificates of insurance, dispute resolution, and contract provision survival following termination;

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- An updated Year 3 work plan and line-item budget were added to the Agreement;
- A new grant payment schedule was provided that included language making future payments conditional on the Coalition's submission and CalOptima Health's acceptance of the upcoming year's work plan and line-item budget; and
- An updated progress report schedule.

The amendment to the Agreement allowed the Coalition to propose a budget for Year 4 that utilized both the anticipated $10.0 million plus the unspent grant amounts from Years 1 through 3 of $5.7 million. While the amendment gave the Coalition the opportunity to propose expending a total of $15.7 million in Year 4, it was conditional on CalOptima Health approving the budget and scope of work.

Discussion

Per the Agreement and amendment, the Coalition submitted its annual scope of work, line-item budget and budget justification, along with the same documents for all 27 sub-recipient clinics (see Attachment 1 for the Coalition's documentation and Attachment 2 for the clinics' documentation) to proceed with Year 4 of the PHVBC initiative. Scopes of work were also provided by the Coalition for the consultants working on the project and can be found in Attachment 3.

The Coalition's overall budget reflected an increase to $15.1 million to execute a similar scope of work as in prior years. While the scope of work submitted with this increased budget was designed to continue advancing the PHVBC initiative, the Grant Management Ad Hoc Committee of the Board determined the cost increase for the scope of work was a material change to the Agreement based on policy AA.1400-Grant Management; thus, the Coalition's request for Year 4 funding required approval from the Board.

Upon review of the Coalition's Year 4 proposals described above, staff identified components needing further explanation – such as common budget line items across several clinics, increased consultant and training costs, and full-time-equivalent staff justification for the Coalition. The Grant Management Ad Hoc Committee of the Board reviewed the submitted documentation along with staff analysis and determined that further documentation was required from the Coalition. This documentation requested by the Grant Management Ad Hoc Committee and provided by the Coalition can be found in Attachment 4.

Staff observed that some clinics' budgets had discrepancies between specified benefits, indirect rates, and related line-item amounts, and one budget did not sum to the requested $443,650. Additionally, the budget template used by clinics showed a $250,000 request limit, which was outdated given the new requested amount of $443,650 per clinic. If this action is approved by the Board, staff will address these issues with the Coalition before proceeding with any Year 4 payments.

Coalition's Update to Annual Budget

The following table provides a summary of grant expenditure increases requested by the Coalition for Year 4, compared to the previous years.

Expense Categories	Year 1 Reported Expenditure	Year 2 Reported Expenditure	Year 3 Reported Expenditure	Year 4 Proposed Budget
Coalition Administration (includes salary, benefits and indirect expenses)	$443,449	$510,164	$754,000	$894,955
Clinic Sub-Awards (27 clinics)	$6,750,000	$6,374,999	$6,833,333	$11,978,550
Program Support (travel, conference fees, supplies, printing, equipment, software, meetings)	$20,813	$92,671	$115,900	$70,251
Consultant Services	$612,339	$770,432	$947,000	$2,150,000
Total Budget	*$7,826,601*	*$7,748,266*	*$8,650,233*	*$15,093,756*

The Coalition's justification for these expenses is presented in Attachments 1, 2 and 3.

Summary of material increase for Coalition administration: The increase in administrative expenses are due to additional staff time and a program manager that has yet to be hired.

Summary of material increase for clinical subawards: Each of the 27 clinic sub-award budgets reflects a 77% increase from the $250,000 awarded to each clinic in Years 1 through 3 to the $443,650 proposed for each clinic in Year 4. Each clinic's scope of work continues to advance their measurable PHVBC objectives in a similar manner to previous years' efforts. The budget enhancements proposed by the Coalition in Year 4 predominantly represent additional consulting and training services.

Summary of material increase in consultant services: The consulting line items in Year 4 reflect a 127% increase over the prior year. Three of the consulting scopes of work describe the communications, training, evaluation, or technical assistance efforts that will take place during Year 4 to support the advancement of this work. The fourth consulting line item is a $400,000 expense placeholder for needs and a consultant(s) that are to-be-determined during the PHVBC Initiative's Year 4.

Fiscal Impact

The recommended action has no additional fiscal impact. A previous Board action on April 7, 2022, appropriated and authorized up to $50 million from existing reserves to fund the Agreement with the Coalition.

Rationale for Recommendation

This action to approve the material change to the grant agreement is recommended by the Grant Management Ad Hoc Committee of the Board. The recommended action aligns with CalOptima Health's obligations for appropriate management of grant agreements.

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Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Coalition's Scope of Work, Budget and Justification
2. 27 Clinics Scopes of Work, Budgets and Justifications
3. Consulting Scopes of Work
4. Additional Information Requested by the Grant Management Ad Hoc Committee

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
April 7, 2022	Authorize appropriation of funds, unbudgeted expenditures and a grant agreement with the Coalition of Orange County Community Health Centers for Population Health and Value-Based Care Transformation	-	$50,000,000
August 7, 2025	Ratify the grant amendment with the Coalition of Orange County Community Health Centers for the Population Health and Value-Based Care Transformation to update terms and conditions related to payment, reporting, and other contract provisions.		$50,000,000

/s/ Michael Hunn *11/26/2025*
Authorized Signature **Date**

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2022-2027 CalOptima Population Health and Transition to Value-Based Care Transformation

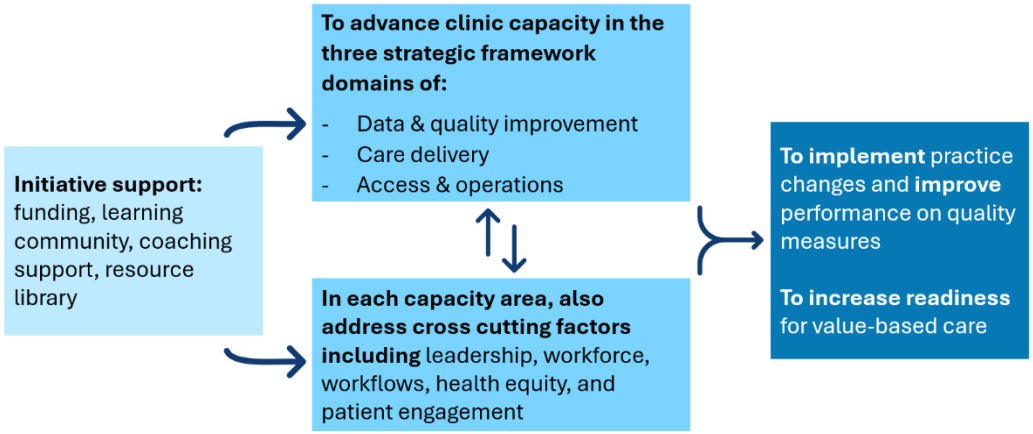
Coalition of Orange County Community Health Centers

Scope of Work (Year Four & Five – 07-01-25 to 06-30-27)

Background

The Population Health and Transition to Value-Based Care (PHVBC) is a $50 million, five (5) year initiative funded by CalOptima Health and lead by the Coalition of Orange County Community Health Centers. This is a single, multi-year initiative designed to drive sustained transformation across the health center safety net. The initiative engages 27 primary care safety net clinics in Orange County to enhance access to care, improve quality outcomes, and strengthen infrastructure of the health care safety net system to transition to value-based care environments.

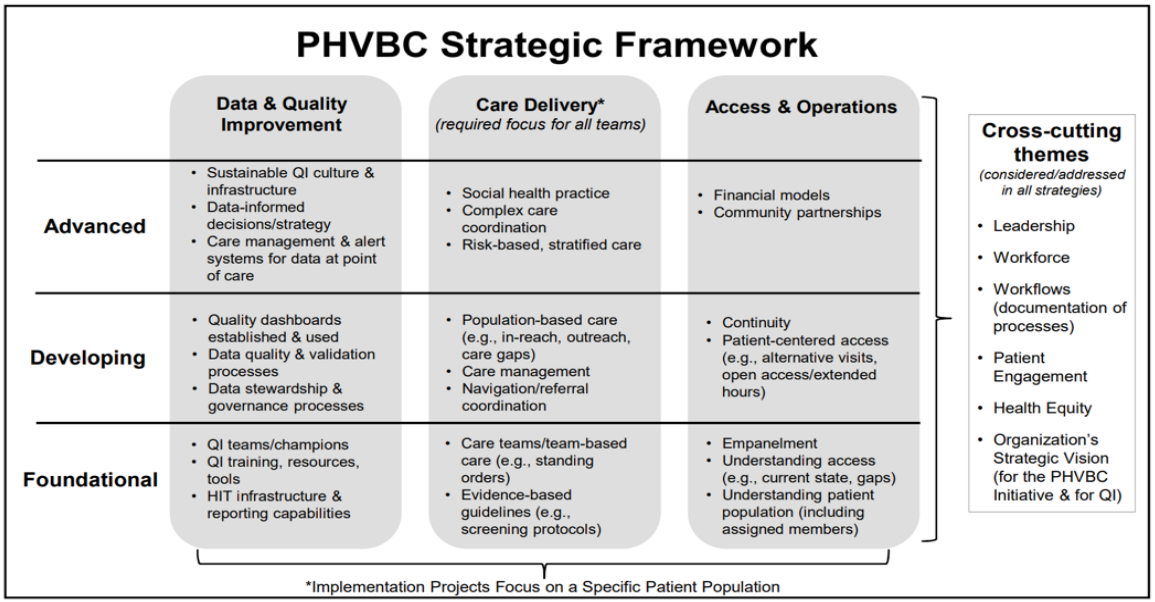
PHVBC is guided by a strategic framework that focuses on building the capabilities of participating clinics in data and quality improvement, care delivery, and access and operations. The initiative is supported by technical assistance and coaching from the Institute for High Quality Care (IHQC) and evaluated by the Center for Community Health and Evaluation (CCHE).



2022-2027 CalOptima Population Health and Transition to Value-Based Care Transformation

Coalition of Orange County Community Health Centers

Scope of Work (Year Four & Five – 07-01-25 to 06-30-27)



2022-2027 CalOptima Population Health and Transition to Value-Based Care Transformation

Coalition of Orange County Community Health Centers

Scope of Work (Year Four & Five – 07-01-25 to 06-30-27)

As we enter the second half of the five-year PHVBC Initiative, Years Four (4) and Five (5) will mark a transition point for the participating teams and their initiative projects. In the first two implementation years of PHVBC, participating health centers were given opportunities to design projects that build systems, service lines, and supports that were foundation to their population health management efforts. Teams were required to pilot these changes and track these improvements via outcomes and process/intervention measures. Participating health center teams were given flexibility to identify the change ideas and systems that were most important to focus on for their clinic and their patients. In Year 4 participating teams will develop their PHVBC Project Work Plans in accordance with updated guidance and expectations that reflect the initiative's evolution. These expectations include:

- **Priority Populations of Focus** – move focused efforts to improve outcomes for specific subpopulations with the broader Medi-Cal Population, as defined by the PHVBC initiative.
- **Scale Up Interventions Countywide** – identify opportunities to expand and spread effective strategies or services piloted through their initiative PHVBC efforts, with the goal of reaching a broader portion of their Orange County Patient Population. With the understanding that there may be resource or operational limitations, teams are expected to actively plan for, and pursue, meaningful scale-up across sites, providers, and/or patient groups where feasible.
- **Standardize Workflows** – participating health center teams will work to standardize these efforts through improved workflow documentation, policies, and training guides for improved long-term sustainability.
- **Incorporate more operational and financial considerations for engaging in Value** – participating health center teams will lay the foundation and infrastructure for assessing operational and financial metrics, in addition to the quality metrics they are already monitoring, to better position for future value-based care and reimbursement efforts.

2022-2027 CalOptima Population Health and Transition to Value-Based Care Transformation

Coalition of Orange County Community Health Centers

Scope of Work (Year Four & Five – 07-01-25 to 06-30-27)

Goal	Objective	Activity	Responsible Party	Timeline
G.1: Strengthen health centers' capacity to scale and sustain population health infrastructure	**O.1** Support health centers in developing and implementing a comprehensive, organization-wide Population health improvement plan that meets PHVBC Year 4 expectations for scale, standardization, and sustainability	**A.1** Distribute updated Year 4 implementation guidance and expectations to all participating health centers: including updated grant management guidelines.	Initiative Level TA Provider (IHQC) VP of Healthcare Operations	July 1, 2025 through June 30, 2027
		A.2. Facilitate virtual and in-person TA sessions to assist clinics in developing clinic level implementation workplan	Initiative Level TA Provider (IHQC)	July 1, 2025 through June 30, 2027
		A.3. Provide TA and coaching (individual and group) to clinics to complete their implementation plan	Initiative Level TA Provider (IHQC)	July 1, 2025 through June 30, 2027
		A.4. Review and approval all clinic-submitted workplans and budgets.	Initiative Level TA Provider (IHQC) VP of Healthcare Operations	July 1, 2025 through June 30, 2027

2022-2027 CalOptima Population Health and Transition to Value-Based Care Transformation

Coalition of Orange County Community Health Centers

Scope of Work (Year Four & Five – 07-01-25 to 06-30-27)

Goal	Objective	Activity	Responsible Party	Timeline
G.2. Advance learning, visibility, and engagement through a digital media strategy.	**O.1.** Promote PHVBC goals, innovations, and community stories by launching a digital medial platform that builds awareness and shared learning.	**A.1.** Develop and launch podcast series highlighting population health innovations in the community health center setting.	VP of Healthcare Operations COO Fourth Street Bridge Strategy Director of Branding & Communications	July 1, 2025 through June 30, 2027
		A.2. Promote PHVBC resources (toolkits, templates, learning sessions) via social media, website, and newsletter	VP of Healthcare Operations Program Manager – HCO Director of Branding and Communications	July 1, 2025 through June 30, 2027
	O.2. Translate evaluation findings and data collected by the evaluation team into concise briefs, infographics, and other visual materials that communicate the initiatives' progress, impact, and lessons learned to diverse audiences in both print and digital formats.	**A.1.** Coordinate with the Initiative level evaluation team to review data collection outputs and identify key findings and stories.	Evaluation Team Fourth Street Bridge Strategy Program Manager HCO Director of Branding and Communications	July 1, 2025 through June 30, 2027
		A.2. Prioritize insights most relevant to each audience segment (e.g. clinics, funders,		July 1, 2025 through June 30, 2027

Goal	Objective	Activity	Responsible Party	Timeline
		policymakers, community)		
		A.3. Develop content formats including briefs, one-pagers, infographics, and presentation slides.		July 1, 2025 through June 30, 2027
		A.4. Design templates for consistent branding across all visual and written materials.		July 1, 2025 through June 30, 2027
G.3. Build Coalition OC's internal capacity to support, evaluate, and sustain value based care transformation initiatives	**O.1.** Develop and implement a structured capability building program with support from the Institute for High Quality Care (IHQC) – to equip Coalition OC healthcare operations, quality, and health information technology staff with the skills, tools, and processes necessary to provide technical assistance, coaching, and peer learning facilitation for member health centers engaged in value-based care transformation.	**A.1:** Collaborate with IHQC to design a project implementation plan to build internal capacity. **A.2:** Participate in IHQC led training sessions on value-based care transformation, best practices, coaching methodologies, and TA frameworks.	COO VP of Healthcare Operations Program Managers HCO Project Manager, Policy Director of QI Data Analyst IHQC	December 2025 through June 30, 2027

2022-2027 CalOptima Population Health and Transition to Value-Based Care Transformation

Coalition of Orange County Community Health Centers

Scope of Work (Year Four & Five – 07-01-25 to 06-30-27)

Goal	Objective	Activity	Responsible Party	Timeline
G.4: Advance coordinated, value-based care for shared Medi-Cal members by fostering cross-organization collaboration, problem-solving, and innovation through the PHVBC Advisory Council	**O.1:** Establish the PHVBC Advisory Council with representatives from clinic teams, the Coalition OC, CalOptima Health, and IHQC to co-design PHVBC supports, identify and address systemic challenges, explore improvement opportunities, and share progress and impact stories.	**A.1.** Identify and confirm Advisory Council members from all stakeholder groups. **A.2.** Develop a charter outlining purpose, roles, responsibilities, and decision-making processes. **A.3.** Schedule and facilitate recurring meetings (e.g. quarterly) to discuss barriers and emerging opportunities, share stories, etc. **A.4.** Capture meeting outcomes and distribute summaries to all stakeholders to ensure follow-through on decisions and next steps.	IHQC Coalition OC	December 31, 2025
G.5. Strengthen the capacity of the participating health centers to successfully implement population health	By June 30, 2027, provide participating health centers with at least 6 targeted training sessions and/or engagements with subject matter experts in specialized areas of	**A.1.** Identify high-priority knowledge gaps in population health and value based care through trends and themes from the initiative, and	VP of Healthcare Operations Program Manager HCO	January 1, 2026 through June 30, 2027

Goal	Objective	Activity	Responsible Party	Timeline
strategies and transition to Value-Based Care through access to specialized training and expert guidance beyond the core technical assistance scope.	population health and value-based care not covered by the primary technical assistance provider, resulting in measurable improvements in organizational readiness and performance in VBC related contracting and care.	TA provider input, feedback from participating health centers. **A.2.** Contract with subject matter experts in niche areas such as risk adjustment, equity centered data use, CMS payment models, best practices from other across the nation, etc. **A.3.** Organize and delivery targeted workshops, role-specific trainings and peer learning exchanges.	Director of QM Data Analyst Policy Analyst	
G.6: Strengthen the capacity of Coalition OC to support members in successfully implemention population health strategies and	By June 30, 2027, provide Coalition OC staff with least 6 targeted training sessions and/or engagements with subject matter experts in specialized areas of population health and	**A.1.** Identify high-priority knowledge gaps in population health and value based care through trends and themes from the initiative, and TA provider input,	VP of Healthcare Operations Coalition OC Staff	January 1, 2026 through June 30, 2027

Goal	Objective	Activity	Responsible Party	Timeline
continuous advancement in creating a value based delivery system through access to specialized training and expert guidance beyond the core technical assistance scope.	value-based care not covered by the primary technical assistance provider, resulting in ehnaced organizational expertise, expanded capacity to guide member health centers.	feedback from participating health centers. **A.2.** Contract with subject matter experts in niche areas such as risk adjustment, equity centered data use, CMS payment models, value based care/payment innovation and transformation, etc. **A.3.** Organize and delivery targeted workshops, role-specific trainings		
G.7. Assess the impact of the Population Health and Transition to Value-based Care Initiative on health centers practice, capabilities and progress toward improve outcomes	O.1. By the end of the initiative, evaluate the changes in health center practices and capabilities, identify facilitators and barriers to implementation and determine how the initiative contributed to overall progress in populatin health	**A.1.** Conduct Capability Self assessment – aligned with strategic framework, for clinics to self-assess current capabilities. Administered at baseline, midpoint, and final	CCHE	Year 5 – Q3

Goal	Objective	Activity	Responsible Party	Timeline
***Note:** Existing evaluation activities will be continuously revisted to ensure continued alignment with initiative priorities and technical assistance strategy.	management and value based care adoption			
		A.2. Initiative Level clinical data reporting- teams submit clinical quality data annually on a select number of clinical metrics for their organizations	CCHE	Year 5- Q1 and Q4
		A.3. Team Interviews – annual virtual interviews with 2-4 members of each PHVBC	CCHE	Year 4 Q3 and Q4; Year 5 Q3 and Q4
		A.4. Participant Survey – Annual PHVBC participant survey to collect information on progress, facilitators, barriers, and satisfaction.	CCHE	Year 4 Q4 and Year Five Q4

Goal	Objective	Activity	Responsible Party	Timeline
		A.5. Project Status Report Review – review of health centers' quarterly progress report and data dashboard to capture key accomplishments, project progress and facilitators and barriers	CCHE	July 1, 2025 through June 30, 2027
		A.6. Health Center Poster Review – document and review to capture health centers' self- reported accomplishments, challenges, and impact.	CCHE	Year 4 (Q4); Year 5 (Q4)
		A.7. In-person convening observations- attending in person convenings to understand content and capture health center updates and stories of impact	CCHE	July 1, 2025-June 30, 2027
		A.8. Post event surveys – implemented for in	CCHE	July 1, 2025 through June 30, 2025

Goal	Objective	Activity	Responsible Party	Timeline
		person convenings and program learning series, as appropriate: a brief survey to assess usefulness and satisfaction and collect recommendations for future events.		
		A.9. Evaluation of Tier One organizations – needing more foundational support to begin their population health work.	CCHE	July 1, 2025 through June 30, 2027
		A.10. Observation of peer groups and other TA offerings – the initiative will be relying on more focused peer groups to deliver content and facilitate peer learnings. As appropriate, CCHE will observe these groups to understand content and capture examples of progress and impact being shared in these venues	CCHE	September 1, 2025-June 30, 2027

Goal	Objective	Activity	Responsible Party	Timeline
		A.11.Case studies/site visits to up to 3 health centers in Year 5	CCHE	July 1, 2026 through June 30, 2027
		A.12. Participation in PHVBC Advisory Council – CCHE will participate in and support the facilitation and materials for these meetings, including b		

Budget/Expenditure/Tracking Report

Organization Name: Coalition of Orange County Community Health

Proposal Title: Population Health Value Based Care Inititive

Initiative Period: July 1, 2022- June 30, 2025

Proposal Expenses	Year 4 (July 1, 2025 to June 30, 2026)
	Budget
Personnel	
COO (.30 FTE)- [redacted]	53,160
CFO (.30 FTE) - [redacted]	52,973
Vice President of Health Center Operations (.50 FTE)- [redacted]	75,842
Director of Branding and Communications (.50 FTE) - [redacted]	66,200
Director of Quality Management (.20 FTE) - [redacted]	29,141
Data Informatics Analyst (.60 FTE)- [redacted]	48,360
Project Manager - Advocacy (1 FTE) - [redacted]	72,858
Program Manager - HCO (.75 FTE) - [redacted]	59,452
Program Manager - HCO (.20 FTE) - [redacted]	17,139
Program Manager - HCO (1 FTE) - TBD	95,000
Accountant (.60 FTE) - [redacted]	42,085
Executive Assistant (.33 FTE) - [redacted]	30,949
Subtotal	643,159
Benefits @ 21 %	135,063
Total Personnel	778,222
Non-Personnel	
Meeting Costs	15,251
Travel and Conference Fees	30,000
Equipment	25,000
Clinics ($443,650 X 27)	11,978,550
Total Non-Personnel	12,048,801
Subtotal Direct Costs	12,827,023
Indirect Costs @ 15 % of Salaries & Benefits	116,733
TOTAL	12,943,756
Other Costs	
Subcontracts/Consultants	
Evaluation (Group Health)	300,000
Communication (4th Street Bridge)	250,000
Technical Assistance (IHQC)	1,200,000
Training and Consultants customized training based on roles; subject matter experts	400,000
Total Other Costs	2,150,000
GRAND TOTAL	15,093,756

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Budget Justification Form

The budget justification is a narrative that explains and justifies the projected expenses attributed to each line item within a project budget and ties the budget to the proposed deliverables and scope of work. The narrative should explain both (1) how the expenses were calculated and (2) how they contribute to achieving the project objectives. Please include a concise narrative for each line item included in your proposed budget.

Specific Line-Item Notes:

- *For personnel, please list separately each position included in this budget, their annual salary (or hourly rate) and the percentage of time dedicated to the project.*
- *For any consultants, identify each unique consultant, the services he/she will perform and how the fees are calculated (e.g. rate of pay, per diem, travel costs, etc.).*
- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
COO (.30 FTE)- [redacted]	53,160	Personnel costs are essential to the successful implementation, oversight, and long-term sustainability of the CalOptima Population Health Initiative. This funding supports key staff responsible for managing the overall grant, coordinating implementation activities, and ensuring effective collaboration between CalOptima Health, technical assistance providers, and participating health centers. The Chief Operating Officer (COO) provides strategic oversight of the initiative, ensuring alignment with the Coalition's mission and organizational priorities.
CFO (.30 FTE) - [redacted]	52,973	The Chief Financial Officer (CFO) provides fiscal oversight for the initiative, ensuring that financial resources are managed effectively and that reporting, compliance, and budget management are conducted with transparency and accuracy.

Line Item*	Amount	Justification
Vice President of Health Center Operations (.50 FTE)- [redacted]	75,842	The Vice President of Healthcare Operations serves as the initiative lead, providing day-to-day leadership and management of all programmatic and operational components. This includes oversight of consultant and clinic engagement, coordination of technical assistance and capacity-building efforts, and management of grant activities, deliverables, and reporting. The VP ensures that strategies are effectively implemented and aligned with the initiative's objectives to advance population health and value-based care.
Director of Branding and Communications (.50 FTE) - I	66,200	The Director of Communications plays a strategic role in elevating the initiative by ensuring that its goals, outcomes, and innovations are clearly articulated and broadly recognized.
Director of Quality Management (.20 FTE) -	29,141	Provides strategic insight on quality improvement and data-driven initiatives to enhance clinic performance, population health outcomes, and the scalability of best practices across the network.
Data Informatics Analyst (.60 FTE)	48,360	The Data Analyst will strengthen internal and member data capacity to advance population health and value-based care goals. This role supports data integration, analysis, and actionable insights to improve outcomes and guide strategic decision-making.
Project Manager - Advocacy (1 FTE) -	72,858	The Project Manager for Advocacy will provide support to the Population Health Initiative by tracking and coordinating policy efforts related to population health and value-based care. This role helps align advocacy activities with program goals and ensures members are informed and engaged on relevant policy developments.
Program Manager - HCO (.75FTE)	59,452	The Program Manager for the Population Health and Value-Based Care Initiative supports participating health centers by coordinating technical assistance,

Line Item*	Amount	Justification
		managing consultants, and facilitating implementation efforts. This role also builds the Coalition's internal capacity to sustain population health and value-based care support beyond the life of the initiative.
Program Manager - HCO (.20FTE)	17,139	The Program Manager for Workforce supports a key pillar of the Population Health and Value-Based Care Initiative by strengthening the health center workforce pipeline and capacity. This role aligns workforce strategies with population health goals to ensure sustainable, high-quality care delivery.
Program Manager - HCO (1 FTE)	95,000	The Program Manager for the Population Health and Value-Based Care Initiative supports member health centers by coordinating technical assistance, managing consultants, and facilitating implementation efforts. This role also builds the Coalition's internal capacity to sustain population health and value-based care support beyond the life of the initiative. Also is being trained on PCMH recognition to support participating health centers.
Accountant (.60 FTE)	42,085	The Accountant supports the Population Health and Value-Based Care Initiative by managing grant funds, processing payments, and ensuring accurate financial tracking and reporting to maintain compliance and fiscal accountability.
Executive Assistant (.33 FTE)	30,949	The Executive Assistant provides administrative and coordination support for the Population Health and Value-Based Care Initiative, ensuring efficient scheduling, communication, and documentation across teams, consultants, and member health centers.
Benefits @ 21 %	135,063	Funding these roles ensures the Population Health and Value-Based Care Initiative has the skilled personnel needed to support member health centers, manage grants effectively, and build internal capacity.

Line Item*	Amount	Justification
		Providing competitive benefits helps attract and retain qualified staff, maintain continuity, and sustain program impact over the initiative's duration.
Meeting Costs	$15,251	Budgeting for meeting costs ensures effective coordination, training, and collaboration among Coalition staff, consultants, and member health centers. This includes expenses for virtual or in-person meetings, materials, and logistics that support program implementation, knowledge sharing, and capacity-building activities.
Travel and Conference fees	$30,000	Budgeting for travel and conference participation supports staff professional development and builds internal capacity to effectively manage the Population Health and Value-Based Care Initiative. Attendance at relevant trainings and conferences enhances skills, knowledge, and best practices that can be applied to support member health centers and sustain program impact.
Equipment	$25,000	Funding for equipment ensures staff have the necessary tools—such as computers, software, and other technology—to efficiently manage the Population Health and Value-Based Care Initiative
Clinics	$11,978,550	Grant funds provided to participating health centers support staff and programmatic costs that enhance their capacity and capability in population health and the transition to value-based care. This investment enables clinics to implement initiative activities, build sustainable internal infrastructure, and improve care delivery outcomes.
Indirect Costs	$116,733	Costs cover benefits and salaries.
Evaluation	$300,000	The Evaluation Team assesses the overall Population Health and Value-Based Care Initiative, measuring program effectiveness, outcomes, and impact. Their work provides

Line Item*	Amount	Justification
		data-driven insights to guide continuous improvement, inform decision-making, and demonstrate the initiative's value to stakeholders and funders.
Communication (4th Street Bridge Strategy)	$250,000	The Communications Team supports the Population Health and Value-Based Care Initiative by translating evaluation findings and program outcomes into tailored communications, including stories, podcasts, and expert-led content. This role enhances knowledge sharing, promotes best practices, and engages stakeholders around value-based care and population health strategies.
Technical Assistance (IHQC)	$1,200,000	Support the Technical Assistance Team in building the capacity of participating health centers through one-on-one coaching, peer learning, and tailored guidance. They also strengthen the Coalition's internal capacity to sustain this work by leading peer groups, convenings, and knowledge-sharing activities that promote long-term adoption of population health and value-based care strategies.
Training and Consultants	$400,000	Funding for training and consultants supports the Coalition's internal capacity-building across all pillars of value-based care. This includes developing staff expertise, implementing best practices, and ensuring the Coalition can effectively support member health centers in population health and value-based care initiatives.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	AltaMed Health Services Corporation
Primary Contact Name and Title:	Maria Topete, MHA, CGMS Grants Manager
Primary Contact Email and Phone Number:	Mtopete@AltaMed.org (323) 765-6653

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, all seven AltaMed Orange County Clinics will increase the number of eligible patients who complete a breast cancer screening by 3%, from 48% (11,508/23,213) to 52% through targeted outreach, patient education and engagement strategies including tailored communication through mailers and root cause analysis to identify barriers for screening completion	☐ Expand current outreach workflow that will identify and contact patients that are noncompliant and offer to book appointment ☐ Launch a targeted education and mailer campaign for women ages 40-50 to increase awareness of new BSC screening changes ☐ Develop report for capturing mammogram utilization of eligible patients in order to obtain data for thorough root cause analysis. ☐ Regularly review performance (outcome and process data) to identify areas of improvement for workflow, incorporate feedback into scripts, workflow or education, etc. implement updated changes to workflows ☐ Training outreach MAs in motivational interviewing (MI).	☐ Breast Cancer Screening Rate, tracked quarterly (all eligible patients)
2. By June 2026, all seven Orange County Clinics will increase the number of eligible patients who complete cervical cancer screening by 3%, from 59% (21.355/36,160) to 62% through targeted outreach, RCA, workflow enhancements and self-testing research	☐ Expand current outreach workflow that will identify and contact patients that are noncompliant and offer to book appointment ☐ Develop scripting and data collection tools to assess barriers and conduct RCA to discover new opportunities to create strategies for completion and optimize workflow for cervical cancer screening ☐ Explore research for self-testing and develop recommendations for appropriate use across AltaMed	☐ Cervical cancer screening rate, tracked quarterly (all eligible patients)

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Line-Item Budget

Clinic Name: AltaMed

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Carry Over	Year 4
Personnel			**Remaining Balance**
[redacted], Director QI	33,860	-	33,860
[redacted] QI Program Manager	23,020	-	23,020
[redacted], QI Clinical Analyst	53,295	-	53,295
[redacted], Manager Quality Reports & Analytics	26,006	-	26,006
[redacted], Medical Assistant	27,851	-	27,851
[redacted], Physician Informacist	33,499	-	33,499
		-	-
Subtotal	**197,531**	-	197,531
			-
Benefits (21.5%)	**61,687**	-	61,687
Total Personnel	**259,218**	-	259,218
Non-Personnel		-	-
Postage for Mail Campaign	4,000		4,000
Translation Fees/Services for Educational Materials	1,000	-	
Printing	2,000		
Alinea Mammography Mobile Unit	7,000	-	
Patient Incentives ($10 card)	20,000		
Health Education/Promotional Materials	22,687	-	22,687
FIT Kits	3,000	-	3,000
Mileage	200	-	200
Training	2,000	-	2,000
Total Non-Personnel	**61,887**	-	61,887
Subtotal Direct Costs	**321,105**	-	321,105
Indirect Costs @ 6%	**18,113**	-	18,113
TOTAL	**339,218**	-	339,218
Other Costs		-	-
Subcontracts/Consultants	104,432	-	104,432
		-	-
		-	-
		-	-
		-	-
		-	-
		-	-
Total Other Costs	**104,432**	-	104,432
		-	-
GRAND TOTAL	**443,650**	-	443,650

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Budget Justification Form- AltaMed

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Specific Line-Item Notes:

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- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
Director QI	$33,860	Quality Improvement lead, back-up project management support, lead on strengthening partnerships with specialty partners
QI Program Manager	$23,020	Project manager, meeting facilitator, coach for PDSA work
QI Clinical Analyst	$53,295	Back-up project management support and data liaison; lead for PDSA work
Manager Quality Reports and Analytics	$26,006	Manages Mas that will be conducting outreach for PHVBC work
Medical Assistant	$27,851	MA identified to conduct outreach for patients and document barriers
Physician Informacist	$33,499	CI/Epic champion, leads efforts to strengthen data reporting efforts and ability to stratify data reports
Benefits (21.5%)	$61,687	Funding these roles ensures the Population Health and Value-Based Care Initiative has the skilled personnel needed to support member health centers, manage grants effectively, and build internal capacity. Providing competitive benefits helps attract and retain qualified staff, maintain continuity,

Line Item*	Amount	Justification
		and sustain program impact over the initiative's duration.
Postage for Mail Campaign	$4,000	Supports mail campaigns enabling the distribution of program materials, outreach information, and educational resources.
Translation Fees/Services for Educational Materials	$1,000	Supports the translation of educational and outreach materials into multiple languages to ensure accessibility for all patient populations served by participating clinics. Providing culturally and linguistically appropriate resources is critical to effective population health management, patient engagement, and health equity.
Printing	$2,000	Supports printing of educational, outreach, and program materials for patients and clinic staff.
Alinea Mammography Mobile Unit	$7,000	Supports the use of a mobile mammography unit to expand access to breast cancer screening for underserved populations. By bringing services directly to communities, the initiative reduces barriers such as transportation and clinic capacity, aligns with population health goals, and supports value-based care by promoting early detection, timely follow-up, and improved health outcomes for patients at risk.
Patient Incentives	$20,000	Supports small incentives to encourage patient engagement and participation-increase attendance at preventive screenings, health education sessions, and chronic disease management programs.
Health Education/Promotional Materials	$22,687	Supports the development and distribution of materials that educate patients on health conditions, preventive care, and available services.
FIT Kits	$3,000	Supports the purchase and distribution of FIT kits for colorectal cancer screening. Providing FIT kits directly to patients increases screening accessibility, encourages early detection, and aligns with population health and value-based care goals by improving preventive care adherence and overall patient outcomes.

Line Item*	Amount	Justification
Mileage	$200	Supports travel expenses for clinic staff, outreach workers, and program personnel conducting patient outreach, home visits, mobile unit services, and community engagement activities.
Training	$2,000	Supports additional staff training that extends beyond the standard technical assistance provided by initiative teams. These trainings enhance clinical, operational, and population health competencies, strengthen staff capacity to implement value-based care practices, and improve patient outcomes.
Indirect Costs	$18,113	Supports the administrative and operational expenses.
Consultants	$104,432	Supports engagement of external consultants who provide specialized expertise and services that advance the Population Health and Value-Based Care Initiative.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Camino Health Center
Primary Contact Name and Title:	Wendy Alexis Quality Improvement Director
Primary Contact Email and Phone Number:	walexis@caminohc.org (949) 240-2030 x243

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, Camino Health Center will increase compliance for Controlling Blood Pressure (CBP) from 49% (450/918) to 64.5% by rolling out a remote patient monitoring program, patient education, and team incentive programs ("Raising the Bar 2.0") across all three sites.	☐ Design and implement a remote patient monitoring program for select patients with hypertension. Train staff and patients in correct use of equipment, develop and implement program components (protocols, telehealth appointments, vendor collaboration, etc.). ☐ Train staff in best practices around hypertension and blood pressure equipment use/documentation. ☐ Work with care teams/data team to address hypertension care gaps at point of care (Raising the Bar 2.0) ☐ Work with data team and care teams to assess and troubleshoot data gaps and discrepancies between our internal data reports and those of our health plan/IPA partners.	☐ Blood pressure in control (<140/90) for hypertensive patients, tracked quarterly (all eligible patients)
2. By June 2026, Camino Health Center will increase compliance for Colorectal Cancer Screening rates from 40% (1,242/3117) to 43.7% by using proactive patient/test monitoring and tracking along with targeted patient outreach and education for overdue patients.	☐ Optimize clinic processes around Cologuard and FIT Kit Distribution and return tracking. ☐ Improve patient education materials on correct collection of FIT sample. ☐ Develop and implement targeted Outreach and Education Campaign for overdue patients through new text messaging reminders, monitoring and close-the loop efforts.	☐ Colorectal cancer screening rate, tracked quarterly (all eligible patients)

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Line-Item Budget

Clinic Name: Camino Health Center

Proposal Title: 2025-2026 Population Health and Transition to Value Base

Proposal Expenses	Budget Year 4	Year 4
Personnel		**Remaining Balance**
[redacted], Quality Improvement Director (90% F	108,769	108,769
[redacted], Quality Improvement Manager (100%	79,910	79,910
[redacted], Clinical Director (37% FTE)	52,831	52,831
		-
		-
		-
		-
Subtotal	**241,510**	241,510
		-
Benefits (25%)	**60,378**	60,378
Total Personnel	**301,888**	301,888
Non-Personnel		-
		-
		-
		-
		-
		-
Total Non-Personnel		-
Subtotal Direct Costs	**301,888**	301,888
Indirect Costs @ 6%	**18,113**	18,113
TOTAL	**320,001**	320,001
Other Costs		-
Subcontracts/Consultants		-
PHVBC Training	123,649	123,649
		-
		-
		-
		-
		-
Total Other Costs	**123,649**	123,649
		-
GRAND TOTAL	**443,650**	443,650

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Budget Justification Form- Camino Health Center

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Specific Line-Item Notes:

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- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
Quality Improvement Director	$108,769	Project manager, meeting facilitator, data steward
Quality Improvement Manager	$79,910	Quality Improvement lead, back-up project management support, lead on strengthening partnerships with specialty partners
Clinical Director	$52,831	Operations lead, supporting team in formalizing workflow and operational changes
Benefits	$60,378	Supports benefits for staff allocated to population health initiative.
Indirect	$18,113	Supports the administrative and operational expenses necessary to support the implementation of the Population Health and Value-Based Care Initiative.
PHVBC Training	$123,649	Supports additional staff training that extends beyond the standard technical assistance provided by initiative teams. These trainings enhance clinical, operational, and population health competencies, strengthen staff capacity to implement value-based care practices, and improve patient outcomes. Investing in advanced or specialized training ensures

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Line Item*	Amount	Justification
		clinics can effectively manage care, engage patients, and meet program goals.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Central City Community Health Centers
Primary Contact Name and Title:	Anna Melendez Quality Improvement Lead
Primary Contact Email and Phone Number:	anmelendez@centralcityhealth.org 323-724-0190 ext. 1022

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 30th, 2026, Central City's Lincoln site will decrease the percentage of diabetic patients with poor A1c control (>9%) from 34% to 29% and increase the percentage of diabetic patients with a documented retinal eye exam by 10%. This will be achieved by implementing real-time EHR alerts to prompt same-day retinal screenings, optimizing the in-clinic retinal screening workflow to integrate screenings during patient intake, and launching a targeted text message campaign to remind patients to complete overdue A1c testing.	☐ Optimize pre-visit planning and EHR alerts, including IT report generation and care team workflows, to empower care teams to address diabetes care gaps for upcoming appointments. ☐ Implement targeted, personalized text-message campaigns to remind diabetic patients about overdue A1c tests and retinal exams. ☐ Promote onsite retinal screening days and work with staff to streamline internal referrals for retinal screening.	☐ Diabetes in poor control (A1c >9), tracked quarterly (all eligible patients at Lincoln site). ☐ Diabetic retinopathy screening rate, tracked quarterly (all eligible patients at Lincoln site).
2. By June 30, 2026, Central City Community Health Center will reduce the no-show rate from by 5% and improve the third next available appointment for Spanish-speaking providers from 30 days to 25 days. This will be achieved by hiring additional bilingual providers, implementing a dedicated call center in Anaheim Lincoln to manage appointment reminders and scheduling, and establishing a process to monitor and optimize provider schedules weekly to better match patient demand.	☐ Hire and onboard additional bilingual providers ☐ Expand the reach of the Anaheim Call Center to support all OC patients with appointment reminders, follow-ups, and assist with rescheduling. ☐ Develop a system where each OC site regularly monitors provider schedules to identify and address bottlenecks or inefficiencies.	☐ No Show rate, tracked quarterly (all eligible appointments in Orange County) ☐ Third next available appointment for Spanish speaking providers, tracked quarterly (all eligible appointments in orange county)

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Line-Item Budget

Clinic Name: Central City Community Health Center Inc.

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Total Project Budget		Requested Amount	
	Year 4	Total	Year 4	Total
Personnel				
1) [redacted] - IT Manager (0.10 FTE)	15,200	15,200	15,200	15,200
2) [redacted] - Data Analyst (0.10 FTE)	14,400	14,400	14,400	14,400
3) [redacted] - QI Coordinator (0.15 FTE)	14,600	14,600	14,600	14,600
Subtotal	44,200	44,200	44,200	44,200
Benefits (14.13%)	6,245	6,245	6,245	6,245
Total Personnel	50,445	50,445	50,445	50,445
Non-Personnel				
Azara Healthcare - Centralized data reporting & Quality measurement	53,000	53,000	53,000	53,000
Press Ganey Associates - To measure and improve quality of care based on Patient Satisfaction analysis.	18,700	18,700	18,700	18,700
		-		-
		-		-
Total Non-Personnel	71,700	71,700	71,700	71,700
Subtotal Direct Costs	122,145	122,145	122,145	122,145
Indirect Costs @ 6%	-	-	-	-
TOTAL	122,145	122,145	122,145	122,145
Other Costs				
Subcontracts/Consultants				
Global Communication - Revenue Generate Services, including Patients Verification Eligibility, Encounter Reconciliation Process and Develop Centralized billing and A/R.	197,855	197,855	197,855	197,855
PHVBC Training	123,650	123,650	123,650	123,650
Total Other Costs	321,505	321,505	321,505	321,505
GRAND TOTAL	443,650	443,650	443,650	443,650

Indirects costs not to exceed 6%
Total requested budget will not exceed $250,000 for year 3

Please insert the position title and the % FTE
The benefit line item has a formula set for 25%. Please adjust to match your organization's standard benefit.
Indirect costs are set at 6%.

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Budget Justification Form- Central City

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Specific Line-Item Notes:

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- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
IT Manager (.10 FTE)	$15,200	This funding supports key personnel essential to the implementation and ongoing advancement of the Value-Based Care and Population Health efforts. These positions are critical to driving system transformation by advancing data-driven quality improvement, care coordination, and population management—activities that are foundational to achieving value-based outcomes.
Data Analyst(0.10 FTE)	$14,400	This funding supports key personnel essential to the implementation and ongoing advancement of the Value-Based Care and Population Health efforts. These positions are critical to driving system transformation by advancing data-driven quality improvement, care coordination, and population management—activities that are foundational to achieving value-based outcomes.
QI Coordinator (.15 FTE)	$14,600	This funding supports key personnel essential to the implementation and ongoing advancement of the

Line Item*	Amount	Justification
		Value-Based Care and Population Health efforts. These positions are critical to driving system transformation by advancing data-driven quality improvement, care coordination, and population management—activities that are foundational to achieving value-based outcomes.
Azara/I2I	*$3,000*	*Centralized data reporting and quality measurement*
Press Ganey Associates	$18,111	*To measure and improve quality of care based on patient satisfaction analysis*
Global Communications	$197,855	Revenue generate services, including patients verification eligibility, encounter reconciliation process and develop centralized billing and A/R
PHVBC *Training*	$123,650	Clinic-level PHVBC training ensures staff can apply initiative strategies within their unique workflows and patient populations. While initiative-level TA provides overarching guidance, this local training reinforces concepts, builds staff competency, and supports the sustainable implementation of value-based care practices, maximizing the impact of centralized technical assistance.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	CHOC Community Pediatrics
Primary Contact Name and Title:	Terri Iler Director, Community Clinical Outreach
Primary Contact Email and Phone Number:	Terri.Iler@choc.org 714.509.8261

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, CHOC Medical Group Clinics will improve the % of patient encounters who have been screened using a PHQ-A/9 screening from 85% (5271/6171) to 90%. We will also improve follow up care for patients who screen positive. This will be accomplished through improving data dashboards and alerts, staff training, and improved referral/ navigation management.	☐ CHOC Social Work and Integrated Primary Care (i.e., Psychology) teams will form a taskforce and work collaboratively to create workflow(s) to close the gap(s) in follow-up appointments, when indicated by a Depression Screening. ☐ CHOC Social Work and ISD teams to partner in creating and launching a dashboard for CHOC Social Work to help monitor metrics like connectivity and follow-up rates. ☐ Provide updated trainings for care team members to identify and refer those initially screened positive	☐ Follow up Rate for patient who screen positive on PHQ-A/9, tracked quarterly (all eligible patients).
2. By June 2026, CHOC Medical Group Clinics will improve CIS Combo 10 Immunization rate from by 5% through staff training to reduce missed opportunities, data validation efforts, developing a Vaccine Hesitancy Taskforce to pilot strategies to common family concerns about vaccines.	☐ Increase call center outreach to families that have not been seen and are due for vaccinations. ☐ Develop a Vaccine Hesitancy Taskforce to review current practices, review best practices, and develop strategies and approaches to empower clinic teams to more effectively address vaccine hesitancy. ☐ Update workflows, pre-visit planning, clinic protocols, and patient education strategies to reduce missed opportunities at closing vaccination gaps.	☐ Child Immunization Status (CIS) Combo 10 vaccination rate, tracked quarterly (all eligible patients)

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	☐ Assess and address data validation issues ensuring that data remains up-to-date across our appropriate systems (i.e., electronic medical record and COZEVA).	

Line-Item Budget

Clinic Name: CHOC

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Carry Over	Year 4
Personnel			**Remaining Balance**
Supervisor, Community Pediatrics (0.30 FTE)	35,462	-	35,462
Practice Manager (0.30 FTE)	25,378	-	25,378
LVN Care Coordinator (0.30 FTE)	35,256	-	35,256
Licensed Clinical Social Worker (0.30 FTE)	43,643	-	43,643
Business Intelligence Developer (0.25 FTE)	-	-	-
Project Manager (0.30 FTE)	41,674	-	41,674
		-	-
Subtotal	**181,413**	-	181,413
			-
Benefits (25%)	**50,796**	-	50,796
Total Personnel	**232,209**	-	232,209
Non-Personnel		-	-
Mileage/Travel	200		200
PCMH Annual Attestation	3,429	-	3,429
Quality improvement Program/Meeting Supplies	3,000	-	3,000
Outside Training (QI, SQ, PM, Data)	15,000	-	15,000
Patient Materials/Giveaways	34,000	-	
Patient Education Lobby Set Up	14,000	-	14,000
Total Non-Personnel	**69,629**	-	69,629
Subtotal Direct Costs	**301,838**	-	301,838
Indirect Costs @ 6%	**18,110**	-	18,110
TOTAL	**319,948**	-	319,948
Other Costs		-	-
Subcontracts/Consultants		-	123,702
Value-based Consultant	123,702	-	#REF!
		-	-
		-	-
		-	-
		-	-
		-	-
Total Other Costs	**123,702**	-	123,702
		-	-
GRAND TOTAL	**443,650**	-	443,650

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Budget Justification Form- CHOC

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Specific Line-Item Notes:

- *For personnel, please list separately each position included in this budget, their annual salary (or hourly rate) and the percentage of time dedicated to the project.*
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- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
Supervisor, Community Pediatrics	$35,462	Provides oversight and guidance for pediatric care programs, supporting patient engagement, care coordination, and population health initiatives to improve child health outcomes within value-based care models.
Practice Manager	$25,378	Oversees clinic operations, staff coordination, and workflow optimization to support effective delivery of population health and value-based care initiatives.
LVN Care Coordinator	$35,256	Provides patient care, care coordination, and follow-up support to enhance engagement, chronic disease management, and population health outcomes within value-based care initiatives.
Licensed Clinical Social Worker	$43,643	Provides behavioral health support, care coordination, and patient advocacy to improve mental health, social well-being, and overall population health outcomes within value-based care initiatives.

Line Item*	Amount	Justification
Business Intelligence Developer		Develops and manages data dashboards, analytics, and reporting tools to support decision-making and drive improvements in population health and value-based care initiatives across clinics.
Project Manager	$41,674	Oversees planning, implementation, and coordination of population health and value-based care initiatives to ensure programs meet goals, timelines, and quality standards.
Benefits (21.5%	$50,796	Supports employee health and other standard benefits.
Mileage/Travel	$200	Supports staff travel for patient outreach, and community engagement to advance population health and value-based care initiatives.
PCMH Annual Attestation	$3,429	Supports activities related to maintaining Patient-Centered Medical Home recognition, ensuring quality standards, care coordination, and adherence to value-based care requirements.
Quality Improvement Program/Meeting	$3,000	Supports meetings to review clinical and operational performance, identify improvement opportunities, and implement strategies that advance population health and value-based care goals.
Outside Training (QI, SQ, PM, Data)	$15,000	Supports staff participation in external trainings on quality improvement, safety and quality, project management, and data analytics to enhance skills and strengthen implementation of population health and value-based care initiatives.
Patient Materials/Giveaways	$34,000	Supports the creation and distribution of educational and promotional materials to engage patients, promote health literacy, and reinforce participation in population health and value-based care initiatives.
Patient Education Lobby Set Up	$14,000	Supports creating engaging lobby displays and materials that educate and inform patients about preventive care, services, and population health initiatives to promote participation and healthy behaviors.

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Line Item*	Amount	Justification
Indirect Costs	$18,110	Supports administrative and operational expenses, including shared organizational resources, that enable effective management and sustainability of population health and value-based care initiatives.
Value-based Consultant	$123,702	Supports engagement of external experts to provide specialized guidance, training, and support beyond standard technical assistance, enhancing clinic capacity to implement and sustain value-based care and population health strategies.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Center for Inherited Blood Disorders (CIBD)
Primary Contact Name and Title:	Janette Zetina Quality Improvement Program Manager
Primary Contact Email and Phone Number:	jzetina@cibd-ca.org 714-221-1200

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, CIBD will increase Annual Visit Adherence Rate from 89% (290/327) to 95% through targeted interventions that improve patient outreach, streamline workflows, and enhance team communication.	☐ Expand team responsible for outreach and establish a weekly outreach schedule. ☐ Implement pre-visit planning through chart reviews and team huddles. ☐ Develop standardized communication scripts for patient outreach.	☐ Annual visit adherence for Hemophilia Patients tracked quarterly (all eligible patients).
2. By June 2026, CIBD will improve coordination with our on-site pharmacy to support patient adherence. The goal is for the pharmacy to contact 100% of patients enrolled in the pharmacy program within 7 days of the provider submitting the prescription, to notify them that their medication is ready and provide next steps.	☐ Develop a standardized pharmacy education checklist or handout for use during annual visits. ☐ Pilot a workflow in which pharmacists or pharmacy technicians participate in annual visits to verify that medication orders have been accurately submitted by the medical provider to the pharmacy	☐ Hemophilia patients who are enrolled in the 340B program and have a prescription script submitted by a medical provider, tracked quarterly
3. By June 2026, CIBD will decrease no show rates from 30% to 19% and improve cycle time by 20% from implementation day through structured outreach strategies and standardized check out workflows.	☐ Implement a structured outreach that includes phone, text, and portal messaging for patients who have previously no-showed. ☐ Design and implement a standardized front desk check-out workflow for annual visits.	☐ No show rate, tracked quarterly, all eligible patients ☐ Cycle time, tracked quarterly, annual visit appointments.

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Line-Item Budget

Clinic Name: CIBD

Proposal Title: 2025-2026 Population Health and Transi

Proposal Expenses	Budget Year 4
Personnel	
1) Operations Director	19,473
2) Research and Special Project Director	18,725
3) Clinic Operations Manager	18,818
4) Quality Improvement Program Manger	110,249
5) Social Worker	21,911
6) Provider	27,349
7) Project Manager	16,984
Subtotal	**233,509**
Benefits (25%)	**58,377**
Total Personnel	**291,886**
Non-Personnel	
Access to care (SDOH)- Gas Cards (Transportation)	$2,500
Food Insecurity (SDOH)- Grocery Cards	$2,500
Patient Social Needs	$5,000
Total Non-Personnel	**10,000**
Subtotal Direct Costs	**301,886**
Indirect Costs @ 6%	**18,113**
TOTAL	**319,999**
Other Costs	
Subcontracts/Consultants	
Consultants	123,651
Total Other Costs	**123,651**
GRAND TOTAL	**443,650**

Indirects costs not to exceed 6%
Total requested budget will not exceed $250,000

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Budget Justification Form- CIBD

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Specific Line-Item Notes:

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Line Item*	Amount	Justification
Operations Director	$19,473	Provides oversight and strategic management of initiative operations, ensuring effective implementation, coordination, and sustainability of population health and value-based care programs across clinics.
Research and Special Project Director	$18,725	Leads research, evaluation, and special projects to inform evidence-based strategies, improve program effectiveness, and advance population health and value-based care initiatives.
Clinic Operations Manager	$18,818	Oversees daily clinic operations, staff coordination, and workflow optimization to support effective delivery of population health and value-based care initiatives.
Quality Improvement Program Manager	$110,249	Oversees planning, implementation, and monitoring of quality improvement initiatives to enhance clinical outcomes and support population health and value-based care goals.

Line Item*	Amount	Justification
Social Worker	$21,911	Provides behavioral health support, care coordination, and patient advocacy to improve mental health, social well-being, and overall outcomes within population health and value-based care initiatives.
Provider	$27,349	Delivers clinical care, manages patient treatment plans, and supports population health and value-based care initiatives to improve patient outcomes and quality of care.
Project Manager	$16, 984	Oversees planning, coordination, and implementation of population health and value-based care initiatives to ensure program goals, timelines, and quality standards are met.
Benefits	$58,377	Supports employee health and other standard benefits.
Access to care (SDOH) – Gas Cards (Transportation)	$2,500	Provides transportation support to patients, reducing barriers to care, improving access to services, and advancing population health and value-based care outcomes.
Food Insecurity (SDOH) – Grocery Cards	$2,500	Provides grocery support to patients facing food insecurity, addressing social determinants of health, promoting nutrition, and improving engagement in population health and value-based care programs.
Patient Social Needs	$5,000	Supports screening, assessment, and interventions for patients' social determinants of health to improve access to resources, engagement in care, and overall population health outcomes.
Indirect Costs	$18,113	Supports administrative and operational expenses that enable effective management, oversight, and sustainability of population health and value-based care initiatives.
Consultants	$123,651	Supports engagement of external experts to provide specialized guidance, training, and services beyond standard initiative-level technical assistance, enhancing

Line Item*	Amount	Justification
		clinic capacity and outcomes in population health and value-based care initiatives.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Celebrating Life Community Health Centers
Primary Contact Name and Title:	Sabrina Cooley, MD CMO
Primary Contact Email and Phone Number:	scooley@clchc.org 949-866-3600

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, Celebrating Life CHC will improve the % of diabetic patients with HbA1c in poor control (>9) from 36% (363/1082) to 29.5% through standardizing the chronic disease management appointment, training staff and providers in our diabetes best practices, and better engaging patients in self-management goal-setting, and increasing chronic disease visits for diabetic patients.	☐ Standardize chronic disease management appointment workflows and protocols, including staff roles/responsibilities and how to employ health education/goal-setting strategies. ☐ Train staff in best practices around diabetes, including hosting monthly population health seminars. ☐ Increase frequency with which chronic disease measures reports are generated and shared with staff. ☐ Chronic disease management team will review monthly care gap reports and tailor outreach efforts to help patients schedule chronic disease appointments and close care gaps. ☐ Expand our SDOH screening efforts and develop strategies that CLCHC can implement to help support the most common barriers to care for our patient population.	☐ HbA1c in poor control (>9) for diabetic patients, tracked quarterly (all eligible patients)
2. By June 2026, Celebrating Life CHC will increase the percentage of hypertensive patients with BP in control (<140/90) from 55% (674/1207) to 64% through standardizing the chronic disease management appointment, training staff and providers in our diabetes	☐ Standardize chronic disease management appointment workflows and protocols, including staff roles/responsibilities and how to employ health education/goal-setting strategies. ☐ Train staff in best practices around hypertension, including hosting monthly population health seminars. ☐ Increase frequency with which chronic disease measures reports are generated and shared with staff.	☐ Blood pressure in control (<140/90) for hypertensive patients, tracked quarterly (all eligible patients)

best practices, and better engaging patients in self-management goal-setting, and increasing chronic disease visits for hypertensive patients.	☐ Chronic disease management team will review monthly care gap reports and tailor outreach efforts to help patients schedule chronic disease appointments and close care gaps. ☐ Expand our SDOH screening efforts and develop strategies that CLCHC can implement to help support the most common barriers to care for our patient population.	

Line-Item Budget

Clinic Name: Celebrating Life Community Health Center

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Carry Over	Year 4
Personnel			**Remaining Balance**
Chief Medical Officer (10% FTE)	35,000	-	35,000
QI/QA Nurse Practitioner (30% FTE)	52,500	-	52,500
Data Analyst (50% FTE)	46,000	-	46,000
Operation Lead (20% FTE)	33,400	-	33,400
Care Coordinator (50% FTE)	36,400	-	36,400
Medical Assistant (45% FTE)	21,500	-	21,500
Patient Engagement and Education (40% FTE)	23,350	-	23,350
Subtotal	**248,150**	-	248,150
			-
Benefits (16%)	**39,704**	-	39,704
Total Personnel	**287,854**	-	287,854
Non-Personnel		-	-
Azara/I2I @1,200/month	14,000	-	14,000
		-	
		-	
		-	
		-	
		-	-
		-	-
		-	-
		-	-
Total Non-Personnel	**14,000**	-	14,000
Subtotal Direct Costs	**301,854**	-	301,854
Indirect Costs @ 6%	**18,111**	-	18,111
TOTAL	**319,965**	-	319,965
Other Costs		-	-
Subcontracts/Consultants		-	-
PHVBC Training	123,685	-	123,685
		-	-
		-	-
		-	-
		-	-
		-	-
Total Other Costs	**123,685**	-	123,685
		-	-
GRAND TOTAL	**443,650**	-	443,650

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Budget Justification Form- Celebrating Life

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Specific Line-Item Notes:

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Line Item*	Amount	Justification
Chief Medical Officer	$35,000	Provides clinical leadership, oversight, and guidance to ensure effective implementation of population health strategies and value-based care initiatives across participating clinics.
QI/QA Nurse Practitioner	$52,500	Supports quality improvement and assurance activities, monitoring clinical outcomes, and implementing evidence-based practices to advance population health and value-based care goals across participating clinics.
Data Analyst	$46,000	Provides data management, analysis, and reporting support to monitor outcomes, inform decision-making, and drive improvements in population health and value-based care initiatives across participating clinics.
Operation Lead	$33,400	Oversees program operations, coordinates initiatives across clinics, and ensures effective implementation of population health and value-based care strategies.
Care Coordinator	$36,400	Supports patient engagement, care navigation, and follow-up to improve health outcomes and advance population health and value-based care goals.

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Line Item*	Amount	Justification
Medical Assistant	$21,500	Provides direct patient support, assists with clinical workflows, and helps implement population health and value-based care activities to improve care delivery and outcomes.
Patient Engagement and Education	$23,350	Supports activities that educate and engage patients in their care, promoting adherence to care plans, preventive services, and overall population health and value-based care goals.
Benefits	$39,704	Supports employee health and other standard benefits
Azara/I2I	$14,000	Support platform for data management, analytics, and reporting to improve clinical outcomes and advance population health and value-based care initiatives.
Indirect	$18,111	Supports administrative and operational expenses necessary to support the implementation of the Population Health and Value-Based Care Initiative.
PHVBC Training	$123,685	Supports additional staff training that extends beyond the standard technical assistance provided by initiative teams. These trainings enhance clinical, operational, and population health competencies, strengthen staff capacity to implement value-based care practices, and improve patient outcomes. Investing in advanced or specialized training ensures clinics can effectively manage care, engage patients, and meet program goals.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	CMI
Primary Contact Name and Title:	Habib Hashmani
Primary Contact Email and Phone Number:	habib@cminc.org

Field Code Changed

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, increase follow-up appointments read and set for incoming patients for A1C so that 35% of diabetic patients seen at clinic have had an A1C	☐ Implement a patient recall and reminder system. ☐ Create a provider dashboard to track A1C follow-ups	☐ % of diabetic patients who leave the clinic with a scheduled follow up A1C appointment. ☐ Number of A1C follow up appointments scheduled per month.
2. By June 2026, improve follow ups for Pap smears, blood pressure and colonoscopy.	☐ Standardize scheduling at point of care – train front desk and clinical staff to book follow-up appointments ☐ Use standing orders or care protocols so follow-up is not dependent only on provider initiation.	☐ % of patients with recommended follow-up completed ☐ % of patients leaving the clinic with follow up appointment scheduled.

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Line-Item Budget

Clinic Name: CMI

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Carry Over	Year 4
Personnel			**Remaining Balance**
Nuring Director (40% FTE)	42,016	-	42,016
Nurse Pracititioner (20% FTE)	24,128	-	24,128
Nurse Pracititioner (20% FTE)	29,744	-	29,744
Nurse Pracititioner (20% FTE)	29,120	-	29,120
Physician	55,000	-	55,000
MA (92%)	43,000	-	43,000
MA (92%)	6,000		
MA (40%)	18,304		
MA(10% FTE)	6,000		
Administration (40%)	40,000		
		-	-
Subtotal	**293,312**	-	293,312
			-
Benefits (25%)	**73,328**	-	73,328
Total Personnel	**366,640**	-	366,640
Non-Personnel		-	-
Medical Supplies	2,000		2,000
Billing Software	44,000	-	44,000
		-	-
		-	-
		-	-
Total Non-Personnel	**46,000**	-	46,000
Subtotal Direct Costs	**412,640**	-	412,640
Indirect Costs @ 6%	**24,758**	-	24,758
TOTAL	**437,398**	-	437,398
Other Costs		-	-
Subcontracts/Consultants		-	-
Strategy Consultants	6,252	-	6,252
		-	-
		-	-
		-	-
		-	-
		-	-
Total Other Costs	**6,252**	-	6,252

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		-	-
GRAND TOTAL	**443,650**	-	443,650

Indirects costs not to exceed 6%

Total requested budget will not exceed $250,000

Please insert the position title and the % FTE
The benefit line item has a formula set for 25%. Please adjust to match your organization's standard benefit.
Indirect costs are set at 6%.

Budget Justification Form- CMI

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Line Item*	Amount	Justification
Nursing Director	$42,016	Provides clinical leadership, oversight, and guidance for nursing staff to ensure high-quality patient care and effective implementation of population health and value-based care initiatives.
Nurse Practitioner	$24,128	Delivers direct patient care, manages treatment plans, and supports population health and value-based care initiatives to improve clinical outcomes and care coordination.
Nurse Practitioner	$29,744	Delivers direct patient care, manages treatment plans, and supports population health and value-based care initiatives to improve clinical outcomes and care coordination.
Nurse Practitioner	$29,120	Delivers direct patient care, manages treatment plans, and supports population health and value-based care initiatives to improve clinical outcomes and care coordination.

Line Item*	Amount	Justification
Physician	$55,000	Provides clinical expertise, oversight, and direct patient care for initiative-related projects, supporting population health management, value-based care implementation, and improved patient outcomes across participating clinics.
Medical Assistant	$43,000	Provides direct patient support, assists with clinical workflows, and helps implement population health and value-based care activities to improve care delivery and outcomes.
Medical Assistant	$6,000	Provides direct patient support, assists with clinical workflows, and helps implement population health and value-based care activities to improve care delivery and outcomes.
Medical Assistant	$18,304	Provides direct patient support, assists with clinical workflows, and helps implement population health and value-based care activities to improve care delivery and outcomes.
Medical Assistant	$6,000	Provides direct patient support, assists with clinical workflows, and helps implement population health and value-based care activities to improve care delivery and outcomes.
Administration	$40,000	Provides essential operational and clerical support to ensure smooth implementation and coordination of population health and value-based care initiatives across clinics.
Benefits	$73,328	Supports employee health and other standard benefits to retain staff and sustain population health and value-based care initiatives.
Medical Supplies	$2,000	Supports the purchase of clinical materials and equipment necessary for patient care, preventive services, and implementation of population health and value-based care initiatives.
Billing Software	$44,000	Supports accurate and efficient billing, claims processing, and revenue management to ensure financial

Line Item*	Amount	Justification
		sustainability and operational efficiency within population health and value-based care initiatives.
Indirect Costs	$24,758	Supports administrative and operational expenses that enable effective management, oversight, and sustainability of population health and value-based care initiatives.
Strategy Consultants	$6,252	Supports engagement of external experts to provide specialized guidance and strategic support beyond standard technical assistance, enhancing clinic capacity, program implementation, and outcomes in population health and value-based care initiatives.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Families Together Orange County
Primary Contact Name and Title:	Helena Brown, Director of Patient Support Services
Primary Contact Email and Phone Number:	helenab@ftoc.us (714) 665-9890 x9018

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 30, 2026, FTOC will improve our cervical cancer screening rate from the current 38% (2,351/6,179) to 45% through focused outreach, performance tracking, and staff engagement.	☐ Run and implement daily huddles to identify patients due for cervical cancer screenings. ☐ Outreach to overdue patients and schedule appointments. ☐ Optimize appointment slots for walk in cervical cancer screening appointments ☐ In preparation for our transition to eClinicalWorks (eCW) in early 2026, we will enhance data workflows and reporting capabilities to enable real-time monitoring and data-driven decision-making.	☐ Cervical cancer screening rate, tracked quarterly (all eligible patients)
2. By June 2026 FTOC will improve our depression screening and follow up rate from 50% (6,601/13,096) to 67% through focused outreach, referrals to behavioral health, performance tracking ,and staff engagement.	☐ Implement daily huddles and standardized depression screening workflows across care team members (coordinators, MA, providers, behavioral health therapists) ☐ Standardize care team processes for completing and reviewing depression screenings and, where appropriate, coordinating follow up supports for the patient. ☐ Optimize appointment slots for virtual depression screenings	☐ Depression screening and follow up rate, tracked quarterly (all eligible patients)

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	☐ Incorporate FindHelp into eCW to track and manage community linkage	
2. By June 2026, we will increase the number of new patients who have established care at Hurtt Family Health from 1545 to 3000 through optimized new patient communications, hosting community events, and continued patient outreach/communications.	☐ Expanded new patient outreach, including texting patients to introduce ourselves as their Primary Care Provider to schedule an appointment. ☐ Host 5-10 Co-Sponsored Community Event, Target Outreach events to underserved zip codes ☐ Optimize New Patient Communications - Text messaging, Call Center Scripts, new patient orientation programs	☐ Number of patients who have established care with Hurtt Family Health, tracked quarterly.
3. By June 2026, Hurtt Family Health will improve various population health metrics including: a) Colorectal Cancer Screening: Increase from 34% (796/2359) to 38% with improved testing with Cologuard. b) Diabetic Patients (HbA1c in Control <9): Improve from 61% (635/1043) to 65% by campaigning clinic-wide friendly competition "Chart-Toppers." c) Breast Cancer Screening: Increase from 47% (505/1086) to 49%, with use of in-house roaming Mammogram events.	☐ Implement Cologuard and fully integrate with eCW ☐ Develop and implement lab and screening reminder texts via i2i to get their screening ☐ Quality Team creating "friendly competition" between clinics to increase measures ☐ Standing orders for patient Colorectal Cancer Screening, diabetes, and breast cancer screening ☐ Providing CalOptima Cancer Screening Incentive Programs education to providers, flyers in exam rooms, and outreach materials to 700 patients located at OCRM. ☐ Operationalize in-house A1c lab testing for patients who have not gone to the lab before their appointment ☐ Partner with Optum for mammogram events at clinic sites ☐ Send staff to a QI conference focused on Azara's latest updates. This will enable our team to enhance data tracking, reporting, and performance monitoring, and maximize the use of these new features. ☐ Equip staff with updated technology, including laptops, tablets, and mobile hotspots, ensuring they can effectively access and apply QI tools in real time; we will strengthen our	☐ Colorectal Cancer Screening Rate, tracked quarterly (all eligible patients) ☐ Breast Cancer Screening Rate, tracked quarterly (all eligible patients) ☐ Diabetes in control (A1c <9), tracked quarterly (all eligible patients)

	ability to use data-driven approaches to improve patient outcomes and organizational performance.	

Line-Item Budget

Clinic Name: Families Together of Orange County

Proposal Title: 2024-2025 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Carry Over	Year 4
Personnel			
Operation and Quality Lead (HB)	46,500	-	46,500
Project Manager (EL)	45,000	-	45,000
Data & IT Analysts (JV)	25,000	-	25,000
Care Coordinator (ZD)	25,000	-	25,000
Care Coordinator (EM)	25,000	-	25,000
Care Coordinator (SM)	25,000	-	25,000
		-	-
Subtotal	**191,500**	-	191,500
			-
Benefits (25%)	**47,875**	-	47,875
Total Personnel	**239,375**	-	239,375
Non-Personnel		-	-
IT Infrastructure	50,000	-	50,000
Training and Skill Building	12,900	-	
Infrastructure and facilities		-	
Patient engagement and education		-	
		-	
		-	-
		-	-
		-	-
		-	-
Total Non-Personnel	**62,900**	-	62,900
Subtotal Direct Costs	**302,275**	-	302,275
Indirect Costs @ 6%	**18,137**	-	18,137
TOTAL	**320,412**	-	320,412
Other Costs		-	-
Subcontracts/Consultants		-	-
Population Health Consultants	57,930	-	57,930
PHVBC Training	65,308	-	65,308
		-	-
		-	-
		-	-
		-	-
Total Other Costs	**123,238**	-	123,238
		-	-
GRAND TOTAL	**443,650**	-	443,650

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CalOptima Health

Budget Justification Form- FTOC

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Specific Line-Item Notes:

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- *For any consultants, identify each unique consultant, the services he/she will perform and how the fees are calculated (e.g. rate of pay, per diem, travel costs, etc.).*
- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
Operation and Quality Lead	$46,500	Oversight of grant function and deliverables
Project Manager	$45,000	Project manager, meeting facilitator, data steward
Data and IT Analysts	$25,000	Oversees EHR change management and implementation
Care Coordinator	$25,000	Tracking and reporting outcomes of screenings, driving improvement change
Care Coordinator	$25,000	Tracking and reporting outcomes of screenings, driving improvement change
Care Coordinator	$25,000	Tracking and reporting outcomes of screenings, driving improvement change
Benefits	$47,875	Supports employee health and other standard benefits to retain staff and sustain population health and value-based care initiatives.
IT Infrastructure	$50,000	Supports software necessary to manage patient data, enable telehealth, and enhance clinic operations in population health and value-based care initiatives.

Line Item*	Amount	Justification
Training and Skill-building	$12,900	Supports training for staff on initiative-specific projects, enhancing skills, knowledge, and capacity to implement population health and value-based care activities effectively.
Indirect Costs	$18,137	Supports administrative and operational expenses that enable effective management, oversight, and sustainability of population health and value-based care initiatives.
Population Health Consultants	$57,930	Supports engagement of external experts to provide specialized guidance and strategic support beyond standard technical assistance, enhancing clinic capacity, program implementation, and outcomes in population health and value-based care initiatives.
PHVBC Training	$65,308	Supports additional training beyond standard technical assistance and project-specific sessions, building staff capacity and expertise in population health management and value-based care to strengthen clinic performance and patient outcomes.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	North Orange County Regional Health Foundation dba Family Health Matters
Primary Contact Name and Title:	Lisa Ramos Chief Operations Officer
Primary Contact Email and Phone Number:	lisa.ramos@fhm-chc.org (714) 441-0411 ext. 8128

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, Family Health Matters will improve the percentage of our diabetic patients with A1c's in poor control (>9) from 25% (249/983) to 15% by expanding empanelment and continuity of care, establishing diabetic care plans, improving patient education and engagement; automating data validation and reporting; and prioritizing care gap closures.	☐ Expand empanelment and continuity of care practices to improve patient engagement. ☐ Standardize A1c testing at each visit to close missing score gaps ☐ Utilize monthly care gap reports to detect and contact non-compliant patients. ☐ Expand number of diabetic patients with an established care plan. ☐ Establish patient education offering including group classes and an online media library.	☐ HbA1c in poor control (>9) for diabetic patients, tracked quarterly (all eligible patients)
2. By June 2026, Family Health Matters will improve the percentage of our eligible patients who have completed a colorectal cancer screening from 47.7% (1,032/2,162) to 57% by expanding access options; utilizing at- home screening and monitoring tools; improving patient education and engagement; automating data validation and reporting; and prioritizing care gap closures.	☐ Promote Cologuard/at-home screenings to improve patient comfort and compliance, and improve patient engagement to promote higher rates of returned and successfully processes FIT Kits. ☐ Create CDSS and text alerts for outstanding FIT kit distribution. ☐ Expand hours of operation to provide more opportunities for screening ☐ Utilize monthly care gap reports to detect and contact non-compliant patients.	☐ Colorectal cancer screening rate, tracked quarterly (all eligible patients)

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Line-Item Budget

Clinic Name: Family Health Matters

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Carry Over	Year 4
Personnel			**Remaining Balance**
[redacted]	53,460	-	53,460
[redacted]	18,360	-	18,360
[redacted]	55,036	-	55,036
[redacted]	22,000	-	22,000
[redacted]	12,400	-	12,400
[redacted]	16,000	-	16,000
[redacted]	16,000	-	16,000
Subtotal	**193,256**	-	193,256
			-
Benefits (18%)	**34,809**	-	34,809
Total Personnel	**228,065**	-	228,065
Non-Personnel		-	-
Empanelment Risk Stratification Consultant	90,000		90,000
		-	-
		-	-
		-	-
		-	
		-	-
Total Non-Personnel	**90,000**	-	90,000
Subtotal Direct Costs	**318,065**	-	318,065
Indirect Costs @ 6%		-	-
TOTAL	**318,065**	-	318,065
Other Costs		-	-
Subcontracts/Consultants		-	1,935
Staff Project Related Training	1,935	-	#REF!
PHVBC Training	123,650	-	123,650
		-	-
		-	-
		-	-
		-	-
Total Other Costs	**125,585**	-	125,585
		-	-
GRAND TOTAL	**443,650**	-	443,650

Indirects costs not to exceed 6%

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Budget Justification Form- FHM

The budget justification is a narrative that explains and justifies the projected expenses attributed to each line item within a project budget and ties the budget to the proposed deliverables and scope of work. The narrative should explain both (1) how the expenses were calculated and (2) how they contribute to achieving the project objectives. Please include a concise narrative for each line item included in your proposed budget.

Specific Line-Item Notes:

- *For personnel, please list separately each position included in this budget, their annual salary (or hourly rate) and the percentage of time dedicated to the project.*
- *For any consultants, identify each unique consultant, the services he/she will perform and how the fees are calculated (e.g. rate of pay, per diem, travel costs, etc.).*
- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
Chief Medical Officer	$53,460	Provider Champion/Clinical Lead – lead on clinical quality measure improvement activities, makes clinical recommendations, shares and reports updates with providers.
Chief Operations Officer	$18,360	Senior Leader/Executive Champion – supports team in navigating challenges, supports operations lead and provider champion; back-up project management support
Data Analyst	$55,036	IT/Data Reporting Champion – lead on data infrastructure, governance, stratification, and reporting
Director of Health Center Operations	$22,000	Operations & QI Champion/Lead – operational lead, supports team in navigating operational changes and formalizing updates or new workflows
Director of Strategic Program Development	$12,400	Project Champion – project management support, provides cross-discipline domain expertise to support strategy building and implementation

Line Item*	Amount	Justification
Quality and Patient Access Specialist	$16,000	Quality and Access Champion – supports clinic leaders in formalizing and adopting changes in workflows, providers EHR/HIT knowledge, and updates EHR system in coordination with workflow needs and strategies
Manager of Community Outreach and Patient Engagement	$16,000	Outreach and Patient Engagement Champion – lead on community partnerships, patient surveys, and social media management
Benefits	$34,809	Supports employee health, retirement, and other standard benefits to retain staff and sustain population health and value-based care initiatives.
Empanelment Risk Stratification Consultant	$90,000	Provides expertise in patient empanelment and risk stratification to optimize population health management, support value-based care initiatives, and improve care coordination and outcomes across participating clinics.
Staff Project Related Training	$1,935	Supports training for staff on initiative-specific projects, enhancing skills, knowledge, and capacity to implement population health and value-based care activities effectively.
PHVBC Training	$123,650	supports additional training beyond standard technical assistance and project-specific sessions, building staff capacity and expertise in population health management and value-based care to strengthen clinic performance and patient outcomes.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Friends of Family Health Center
Primary Contact Name and Title:	Ivy Phan QAQI Manager
Primary Contact Email and Phone Number:	iphan@fofhealthcenter.org (562) 501-1682

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, Friends of Family Health Center will decrease the percentage of diabetic patients with uncontrolled HbA1c from 24% (408/1687) to 23%.	☐ Refine and optimize workflows for ordering and monitoring completion of necessary labs, including EHR alerts, care coordination, and patient appointment self-scheduling. ☐ Expand patient outreach by proactively reaching out to patients due for an A1c test and patients who are due for follow-up diabetes visits. ☐ Enhance patient education through improved diabetes education materials (including recipes, infographics, and food substitution guides in English and Spanish). ☐ Test, optimize, and implement new capabilities in EHR to support patient self-scheduling functions.	☐ Diabetes in poor control (HbA1c >9) tracked quarterly (all eligible patients).
2. By June 2026, Friends of Family Health Center will improve cervical cancer screening rates from 51% (2184/4280) to 54%.	☐ Streamline and standardize patient education materials, including digital health tools like PatientPoint. ☐ Explore feasibility of Pap self-collection test and, if determined to be feasible, pilot implementation.	☐ Cervical cancer screening rate, tracked quarterly (all eligible patients)

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Line-Item Budget

Clinic Name: Friends of Family Health Center

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Carry Over	Year 4
Personnel			
Director of Information Technology (20% FTE)	36,000	-	36,000
MD, Director of Clinical Informatics (10% FTE)	29,760	-	29,760
Quality Manager (50% FTE)	46,800	-	46,800
LVN, Clinical Quality Compliance Manager (50% FTE	43,680	-	43,680
Community Engagement Manager (50% FTE)	32,240	-	32,240
		-	-
		-	-
Subtotal	**188,480**	-	188,480
			-
Benefits (20.5%)	**38,638**	-	38,638
Total Personnel	**227,118**	-	227,118
Non-Personnel		-	-
		-	-
		-	
		-	
		-	
		-	
		-	-
		-	-
		-	-
		-	-
Total Non-Personnel		-	-
Subtotal Direct Costs	**227,118**	-	227,118
Indirect Costs @ 6%	**13,627**	-	13,627
TOTAL	**240,745**	-	240,745
Other Costs		-	-
Subcontracts/Consultants		-	-
into 2 new clinics	79,254	-	79,254
PHVBC Training	123,651	-	123,651
		-	-
		-	-
		-	-
		-	-
Total Other Costs	**202,905**	-	202,905
		-	-
GRAND TOTAL	**443,650**	-	443,650

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Budget Justification Form- FOF

The budget justification is a narrative that explains and justifies the projected expenses attributed to each line item within a project budget and ties the budget to the proposed deliverables and scope of work. The narrative should explain both (1) how the expenses were calculated and (2) how they contribute to achieving the project objectives. Please include a concise narrative for each line item included in your proposed budget.

Specific Line-Item Notes:

- *For personnel, please list separately each position included in this budget, their annual salary (or hourly rate) and the percentage of time dedicated to the project.*
- *For any consultants, identify each unique consultant, the services he/she will perform and how the fees are calculated (e.g. rate of pay, per diem, travel costs, etc.).*
- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
Director of Information Technology (20% FTE)	$36,000	IT champion
MD, Director of Clinical Informatics (10% FTE)	$29,760	Provider champion, sharing updates and building engagement with other providers and with care teams
Quality Manager (50%)	$46,800	Project manager, meeting facilitator, data steward, quality measure management
LVN, Clinical Quality Compliance Manager (50%)	$43,680	Clinical input, operations lead, liaison to clinical staff and providers
Community Engagement Manager (50% FTE)	$32,240	Community outreach, patient feedback, building engagement with staff and patients
Benefits	$38,638	Supports employee health and other standard benefits to retain staff and sustain population health and value-based care initiatives.
Indirect costs	$13,627	Supports administrative and operational expenses that enable effective management, oversight, and sustainability

Line Item*	Amount	Justification
		of population health and value-based care initiatives.
Renovation/Alteration of approximately 7,500 sq. ft. into 2 new clinics	$79,254	Supports the renovation and adaptation of approximately 7,500 sq. ft. of space to establish two new clinics, expanding access to care and enabling delivery of population health and value-based care services to additional patients.
PHVBC Training	$123,651	Supports additional training beyond standard technical assistance and project-specific sessions, building staff capacity and expertise in population health management and value-based care to strengthen clinic performance and patient outcomes.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Hurtt Family Health Clinic
Primary Contact Name and Title:	Courtnee Hastings *Director of Nursing/Risk Manager* Alejandra Vargas *Quality & Compliance Manager* Jina Lawler *President & CEO*
Primary Contact Email and Phone Number:	Courtnee.hastings@hurttclinic.org (714) 338-0695 Alejandra.vargas@hurttclinic.org (714) 247-4380 Jina.lawler@hurttclinic.org (714) 441-8044

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, Hurtt Family Health will have screened over 75% of its active patients for SDOH needs, risk stratified over 40% of our active patients by clinical and social needs, and connect 20% of our high risk patients with case management and navigation support.	☐ Embed our SDOH screening tool into our EMR ☐ Train staff in SDOH screening workflow ☐ Automate risk stratification reporting, and train staff in referral workflows to connect high-risk patients with case management team. ☐ Expand patient outreach by proactively reaching out to patients due for an A1c test and patients who are due for follow-up diabetes visits. ☐ Develop a workflow in eCW to track and document SDOH and include in individual care plans	☐ SDOH Screening completion rate for active patients, tracked quarterly. ☐ High risk, active patients connected to case management/navigation supports, tracked quarterly.

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Line-Item Budget

Clinic Name: HURTT FAMILY HEALTH CLINIC

Proposal Title: 2025-2026 Population Health and Transition to Value

Proposal Expenses	Total Project Budget	
	Year 4	Total
Personnel		
Director of Nursing (20%FTE)	26,000	26,000
Chief Medical Officer (20%FTE)	53,000	53,000
Provider (40%)	56,000	56,000
Quality & Compliance Manager (20% FTE)	17,000	17,000
EMR Data Analyst (40% FTE)	30,000	30,000
LVN (20%)	11,320	11,320
		-
Subtotal	193,320	193,320
Benefits (22%)	42,530	42,530
Total Personnel	235,850	235,850
Non-Personnel		
Travel	10,000	10,000
Training	10,000	10,000
Software i2i Health & Microsoft Power BI	24,036	24,036
iPad Tablets	12,000	12,000
IT Setup & Support	10,000	10,000
		-
Total Non-Personnel	66,036	66,036
Subtotal Direct Costs	301,886	301,886
Indirect Costs @ 6%	18,113	18,113
TOTAL	320,000	320,000
Other Costs		
Subcontracts/Consultants		
		-
		-
Total Other Costs	-	-
GRAND TOTAL	320,000	320,000

Indirects costs not to exceed 6%

Please insert the position title and the % FTE
The benefit line item has a formula set for 25%. Please adjust to match your organizatio
Indirect costs are set at 6%.

Budget Justification Form- Hurtt

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Specific Line-Item Notes:

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- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
Director of Nursing (20% FTE)	$26,000	Project Manager, Team Lead, supporting team in formalizing workflow and operational changes
Chief Medical Officer (20% FTE)	$53,000	Provider champion, lead on clinical quality measures improvement efforts, sharing updates and building engagement with other providers and with care teams
Provider (40% FTE)	$56,000	
Quality and Compliance Manager (40% FTE)	$17,000	Quality Improvement lead, back-up project management support, lead on strengthening partnerships with specialty partners
EMR Data Analyst (40% FTE)	30,000	Provides data extraction, analysis, and reporting from the electronic medical record to support population health management, quality improvement, and value-based care initiatives.
LVN (20% FTE)	$11,320	Provides clinical support and care coordination on a part-time basis to assist with patient management, preventive

Line Item*	Amount	Justification
		care, and population health initiatives within value-based care programs.
Benefits	$42,530	Supports employee health and other standard benefits to retain staff and sustain population health and value-based care initiatives.
Travel	$10,000	Supports staff travel for patient outreach, site visits, training, and community engagement to advance population health and value-based care initiatives.
Training	$10,000	Supports staff development and skill-building to enhance capacity for implementing population health and value-based care initiatives effectively.
Software i2i Health and Microsoft Power BI	$24,036	Supports data management, analytics, and reporting tools to track clinical outcomes, identify gaps in care, and inform decision-making for population health and value-based care initiatives.
iPad Tablets	$12,000	Supports mobile access to electronic health records, patient education, and care coordination tools, enhancing efficiency and effectiveness of population health and value-based care initiatives.
IT Setup and Support	$10,000	Provides installation, maintenance, and technical assistance for software, and networks to ensure effective operation of population health and value-based care initiatives.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	KCS
Primary Contact Name and Title:	Christopher Le QI Manager
Primary Contact Email and Phone Number:	chrle@kcsinc.org 714-527-6561 ext. 11552

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, KCS will improve breast cancer screening rates from 62% (819/1316) to 70%.	☐ Fully integrate breast cancer screening status review into all site's morning huddles and pre-visit planning checklists. ☐ Standardize workflows to identify and conduct outreach to at least 70% of patients due or overdue for breast cancer. ☐ Implement clinical standing orders for clinic staff to issue mammogram referrals	☐ Breast cancer screening rate, tracked quarterly (all eligible patients)
2. By June 2026, KCS will improve depression screening and follow up for patients 12 y/o and older, by increasing depression screening from 58% (3,577/6181) to 65%, and follow up on positive screenings from 37% (354/949) to 42%.	☐ Fully integrate depression screening review into all site's morning huddles and pre-visit planning checklists ☐ Standardize and implement workflows for depression screening and follow-up plan documentation, including timely PHQ-9 reassessments after positive screen, across all clinic sites ☐ Provide culturally and linguistically tailored outreach and engagement training to all lead care managers and outreach staff	☐ Depression screening and follow up rate, tracked quarterly (all eligible patients)

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Line-Item Budget

Clinic Name: KCS

Proposal Title: 2025-2026 Population Health and Transition to Value Base

Proposal Expenses	Budget Year 4	Carry Over
Personnel		
Program Manager (0.5 FTE) - [redacted]	**47,500.00**	
Next Gen QI Data Specialist (1 FTE) - [redacted]	**54,429.00**	
QI Lead (0.5 FTE) - [redacted]	**45,000.00**	
Medical Assistant (1 FTE) - [redacted]	**54,000.00**	
Clinical champion (0.1 FET) - [redacted]	**13,680.00**	
Subtotal	**214,609.00**	
Benefits (25%)	**25,391.00**	
Total Personnel	**240,000.00**	
Non-Personnel		
Training and Support for staff	10,000	
Patient engagement and education	10,000	
Infrastructure and facilities	41,887	
Total Non-Personnel	**61,887**	
Subtotal Direct Costs	**301,886.79**	
Indirect Costs @ 6%	**18,113.21**	
TOTAL	**320,000.00**	
Other Costs		
Subcontracts/Consultants		
PHVBC Training	123,650.00	
Total Other Costs	**123,650.00**	
GRAND TOTAL	**443,650.00**	

Indirects costs not to exceed 6%
Total requested budget will not exceed $250,000

Please insert the position title and the % FTE

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Budget Justification Form- KCS

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Specific Line-Item Notes:

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Line Item*	Amount	Justification
Program Manager (50% FTE)	$47,500	Oversees planning, coordination, and implementation of population health and value-based care initiatives on a part-time basis to ensure program goals, timelines, and quality standards are met.
Next Gen QI Data (100% FTE)	$54,429	Provides full-time data management, analysis, and reporting to support quality improvement, population health management, and value-based care initiatives across participating clinics.
QI Lead (50% FTE)	$45,000	Provides part-time leadership for quality improvement initiatives, guiding data-driven strategies and supporting population health and value-based care goals across participating clinics.
Medical Assistant (100% FTE)	$54,000	Provides full-time clinical support, assists with patient care and workflows, and helps implement population health and value-based care initiatives to improve patient outcomes and care delivery.

Line Item*	Amount	Justification
Clinical Champion (10% FTE)	$13,680	Provides part-time leadership and guidance to promote best practices, support clinical staff, and advance population health and value-based care initiatives within the clinic.
Benefits	$25,391	Supports employee health, retirement, and other standard benefits to retain staff and sustain population health and value-based care initiatives.
Training and Support for staff	$10,000	Provides education, skill-building, and ongoing support to enhance staff capacity and effectiveness in implementing population health and value-based care initiatives.
Patient engagement and education	$10,000	Supports activities and materials that educate and engage patients, promoting adherence to care plans, preventive services, and improved outcomes within population health and value-based care initiatives.
Infrastructure and facilities	$41,887	Supports the development, maintenance, and optimization of physical and operational resources necessary to deliver effective population health and value-based care services.
Indirect Costs	$18,113.21	Supports administrative and operational expenses that enable effective management, oversight, and sustainability of population health and value-based care initiatives.
PHVBC Training	$123,650	Supports additional training beyond standard technical assistance and routine staff development, building capacity in population health management and value-based care to strengthen clinic performance and patient outcomes.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Laguna Beach
Primary Contact Name and Title:	Jorge Rubal, MD, CEO & CMO
Primary Contact Email and Phone Number:	jrubal@lbclinic.org

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, increase the total number of unique patients who have established care with Behavioral Health provider team.	☐ Develop internal workflows, policies and documentation needed for these services.	☐ Preventative Care and Screening for Depression and Follow-Up plans
2. By June 2026, expand QI/QA capacity through hiring of a Quality Manager.	☐ Develop Quality Improvement Plan ☐ Improve identification, tracking and reporting on quality indicators. ☐ Improve statistical analysis of patient care ☐ Create processes to provide data to drive decision making to increase quality measures.	☐ Care gap closure in diabetes and HTN

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Line-Item Budget

Clinic Name: Laguna Beach

Proposal Title: 2023-2024 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Carry Over	Year 4
Personnel			**Remaining Balance**
Registered Dietitian (50% FTE)	50,000	-	50,000
LMFT (50% FTE)	60,638	-	60,638
Quality Manager (100% FTE)	120,000	-	120,000
		-	-
		-	-
		-	-
		-	-
Subtotal	**230,638**	-	230,638
			-
Benefits (25%)	**57,660**	-	57,660
Total Personnel	**288,298**	-	288,298
Non-Personnel		-	-
			-
		-	-
		-	-
		-	-
		-	-
Total Non-Personnel	**-**	-	-
Subtotal Direct Costs	**288,298**	-	288,298
Indirect Costs @ 6%	**17,298**	-	17,298
TOTAL	**305,595**	-	305,595
Other Costs		-	-
Subcontracts/Consultants		-	-
Training	138,055	-	138,055
		-	-
		-	-
		-	-
		-	-
		-	-
Total Other Costs	**138,055**	-	138,055
		-	-
GRAND TOTAL	**443,650**	-	443,650

Indirects costs not to exceed 6%
Total requested budget will not exceed $250,000

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Budget Justification Form- Laguna Beach

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Specific Line-Item Notes:

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- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
Registered Dietician (50% FTE)	$50,000	Provides part-time nutrition counseling, care coordination, and patient education to support healthy behaviors, chronic disease management, and population health and value-based care initiatives.
LMFT (50% FTE)	$60,638	Provides part-time behavioral health services, counseling, and care coordination to support patients' mental health, social well-being, and population health outcomes within value-based care initiatives.
Quality Manager (100% FTE)	$120,000	Provides full-time oversight of quality improvement initiatives, monitors clinical outcomes, and implements strategies to advance population health and value-based care goals across clinics.
Benefits	$57,660	Supports employee health and other standard benefits to retain staff and sustain population health and value-based care initiatives.

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Line Item*	Amount	Justification
Indirect Costs	$17,298	Supports administrative and operational expenses that enable effective management, oversight, and sustainability of population health and value-based care initiatives.
Training	$138,055	Supports additional training beyond standard technical assistance and routine staff development, building capacity in population health management and value-based care to strengthen clinic performance and patient outcomes.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Lestonnac Free Clinic
Primary Contact Name and Title:	Mary Baker Quality and System Integration Manager/FNP
Primary Contact Email and Phone Number:	mbaker@lestonnacfreeclinic.org (714) 633-4600 x1012

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, Lestonnac Free Clinic aims to increase the percentage of members aged 18–75 with hypertension whose blood pressure is adequately controlled from 60% (2049/3391) to 66% through expanded patient education materials and approaches, , implementing appointment reminders, and incentivizing staff and providers to focus on improving hypertension management	☐ Create dashboards and charts to share progress among staff. ☐ Install and utilize interactive tablets and screens in exam rooms to deliver culturally and linguistically appropriate educational content on hypertension. Content will include information about the importance of medication adherence, lifestyle modifications (diet, exercise, stress reduction), home blood pressure monitoring, and the risks of uncontrolled hypertension. ☐ Implement a reminder system (text messages) to support patients in consistent follow-up care and medication refill to enhance mediation adherence.	☐ Blood pressure in control (<140/90) tracked quarterly (all eligible patients).
2. By June 2026, Lestonnac Free Clinic aims to increase the percentage of members aged 18–75 with diabetes who have their condition adequately controlled from 35% (942/2693) to 45% through expanded patient education materials and approaches, , implementing appointment reminders, and incentivizing staff and providers to focus on improving diabetes management	☐ Create dashboards and charts to share progress among staff. ☐ Install and utilize interactive tablets and screens in exam rooms to deliver culturally and linguistically appropriate educational content on hypertension. Content will include information about the importance of medication adherence, lifestyle modifications (diet, exercise, stress reduction), home blood pressure monitoring, and the risks of uncontrolled hypertension. ☐ Implement a reminder system (text messages) to support patients in consistent follow-up care and medication refill to enhance mediation adherence.	☐ Diabetes in adequate control (HbA1c <8) tracked quarterly (all eligible patients)

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3. By June 30, 2026, Lestonnac Free Clinic will reduce the patient no-show rate from 22% to 17%, by expanding telehealth services, implementing staff follow-up calls to reschedule missed appointments, and increasing patient awareness of healthcare access options through targeted outreach.	☐ Develop protocols and workflows for offering more telehealth appointments for patients where clinically appropriate. ☐ Standardize front office no show workflows to include timely patient contact following no show to reschedule.	☐ No show rate, tracked quarterly, primary care patient appointments.

Line-Item Budget

Clinic Name: Lestonnac Free Clinic

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Carry Over	Year 4
Personnel			
1) Quality Lead/Project Manager (0.67 FTE)	$100,000	-	100,000
2) IT Lead (0.25 FTE)	$17,200	-	17,200
3) Operations Lead (0.20 FTE)	$21,500	-	21,500
4) Case Manager (0.25 FTE)	$20,800	-	20,800
5) Front Desk (0.50 FTE)	$20,800	-	20,800
6) Back Office (0.50 FTE)	$20,800	-	20,800
		-	-
Subtotal	**201,100**	-	201,100
			-
Benefits (15%)	**30,165**	-	30,165
Total Personnel	**231,265**	-	231,265
Non-Personnel		-	-
Supplies	$6,471		6,471
IT Expenses	$30,000	-	30,000
Direct Patient Costs	$20,000	-	20,000
		-	-
		-	-
Total Non-Personnel	**56,471**	-	56,471
Subtotal Direct Costs	**287,736**	-	287,736
Indirect Costs @ 6%	**17,264**	-	17,264
TOTAL	**305,000**	-	305,000
Other Costs		-	-
Subcontracts/Consultants		-	-
		-	-
Staff Development	$15,000	-	15,000
PHVBC Training	$123,650	-	123,650
		-	-
		-	-
		-	-
Total Other Costs	**138,650**	-	138,650
		-	-
GRAND TOTAL	**443,650**	-	443,650

Indirects costs not to exceed 6%
Total requested budget will not exceed $250,000

Please insert the position title and the % FTE

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Budget Justification Form- Lestonnac

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Specific Line-Item Notes:

- *For personnel, please list separately each position included in this budget, their annual salary (or hourly rate) and the percentage of time dedicated to the project.*
- *For any consultants, identify each unique consultant, the services he/she will perform and how the fees are calculated (e.g. rate of pay, per diem, travel costs, etc.).*
- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
Quality Lead/Project Manager (67% FTE)	$100,000	Project manager, meeting facilitator, data steward
IT Lead (25% FTE)	$17,200	Lead efforts to strengthen data reporting efforts and ability to stratify data reports
Operations Lead (20% FTE)	$21,500	Supporting team in formalizing workflow and operational changes
Case Manager (25% FTE)	$20,800	Coordination across different points of care and multidisciplinary teams to enhance care access, quality of care, and patient health outcomes
Front Desk (50 % FTE)	$20,800	Supports patient intake, scheduling, and administrative coordination to ensure smooth clinic operations and effective delivery of population health and value-based care services.
Back Office (50% FTE)	$20,800	Provides essential clinical and administrative support to ensure efficient patient care workflows, accurate documentation, and the successful implementation of population health and value-based care initiatives.

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Line Item*	Amount	Justification
Benefits	$30,165	Covers employee health and other standard.
Supplies	$6,471	Provides necessary materials and resources for front- and back-office staff to support daily operations, patient care, and the effective implementation of population health and value-based care activities.
IT Expenses	$30,000	Supports technology infrastructure, software needed for data management, reporting, and secure communication to effectively implement and sustain population health and value-based care initiatives.
Direct Patient Costs	$20,000	Covers expenses directly associated with patient care, including screening, preventive services, and interventions that support improved population health outcomes and value-based care delivery.
Staff Development	$15,000	Supports professional development, training, and continuing education to enhance staff skills and capacity for delivering high-quality population health and value-based care services.
PHVBC Training	$123,650	Supports staff participation in population health and value-based care training to build knowledge, skills, and capacity for effective implementation across participating health centers. Building organizational capacity.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Livingstone Community Health Clinic
Primary Contact Name and Title:	Kyung I. Park, MD Founder & CEO of Livingstone Community Development Corporation
Primary Contact Email and Phone Number:	kipark@livingstonecdc.com 714-248-9500

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, Livingstone Community Health Clinic will improve its colorectal cancer screening rate from 45.50% (278/611) to 50%	☐ Systemic and Targeted Outreach, including bi-monthly FIT kit outreach list review and outreach ☐ Expand guides for staff education and cross training, helping to standardize our colorectal cancer screening workflows, eCW workflows, and visual training aids ☐ Adopt new EHR changes, including eCW's new pre-visit planning "To-Do list" features (sunsetting eCW's previous "huddle reports") to empower care teams with actionable and meaningful alerts	☐ Colorectal Cancer Screening Rate, tracked quarterly (all eligible patients)
2. By June 2026, LCHC will improve its Initial Health Appointment completion percentage from 11.31% (58/513) to 15%	☐ Simplify new patient registration process as well as IHA process ☐ Optimize strategies for getting patient record and proactively compile care gap reports for patients assigned but unseen at LCHC ☐ Develop postcards, welcome kits, swags that may attract new patients	☐ Initial Health Appointment completion rate within 120 days, tracked quarterly (newly assigned patients)
3. By June 30, 2026, Livingstone will strengthen its IT and Data reporting capabilities.	☐ Complete eCW and OCPH HIE interface and onboarding ☐ Complete interface between AltaMed COZEVA and LCHC eCW ☐ Adopt and implement eCW's new features; e.g., To-Do list, Clinical Quality Worksheet, Clinical Rule Engine (currently in use; adopt for more measures), Questionnaires, etc.	☐ Completed implementation of multiple interfaces and launch of additional eCW features. (Implementation milestone tracking on a quarterly basis)

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Line-Item Budget

Clinic Name: Livingstone Community Health Center

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Carry Over	Year 4
Personnel			
QI Manager (100% FTE)	$54,000	-	54,000
Data Analyst (50% FTE)	$27,000	-	27,000
Family Practice for Population Health (45% FTE)	$129,870	-	129,870
Front office scheduling (100% FTE)	$40,404	-	40,404
		-	-
		-	-
		-	-
Subtotal	**251,274**	-	251,274
			-
Benefits (15%)		-	-
Total Personnel	**251,274**	-	251,274
Non-Personnel		-	-
Office supply for tests & outreach	$2,042		2,042
EMR expenses (44,781 10%)	$4,478	-	4,478
EMR UDS eBO Package	$1,438	-	1,438
		-	-
		-	-
Total Non-Personnel	**7,958**	-	7,958
Subtotal Direct Costs	**259,232**	-	259,232
Indirect Costs @ 6%	**15,554**	-	15,554
TOTAL	**274,786**	-	274,786
Other Costs		-	-
Subcontracts/Consultants		-	-
PCMH Consultant	$8,000	-	8,000
PHVBC Training	$160,864	-	160,864
		-	-
		-	-
		-	-
		-	-
Total Other Costs	**168,864**	-	168,864
		-	-
GRAND TOTAL	**443,650**	-	443,650

Indirects costs not to exceed 6%

Please insert the position title and the % FTE

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Budget Justification Form- Livingstone

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Specific Line-Item Notes:

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Line Item*	Amount	Justification
QI Manager (100% FTE)	$54,000	Leads clinical quality measures improvement efforts and leads efforts to strengthen data reporting
Data Analyst (50% FTE)	$27,000	Lead efforts to strengthen data reporting efforts and ability to stratify data reports
Family Practice for Population Health (45% FTE)	$129,870	Provides clinical care and population health management, supporting preventive services, chronic disease management, and value-based care initiatives to improve patient outcomes.
Front office scheduling (100% FTE)	$40,404	Supports patient scheduling, registration, and administrative coordination to ensure timely access to care and smooth operations within population health and value-based care initiatives.
Office supplies for tests and outreach	$2,042	Supports materials and supplies needed for patient testing, educational activities, and outreach efforts to promote engagement and participation in population health and value-based care initiatives.

Line Item*	Amount	Justification
EMR expenses ($44,781 – 10%)	$4,478	Supports electronic medical record systems, including licensing, maintenance, and updates, to enable accurate patient data management, care coordination, and reporting for population health and value-based care initiatives.
EMR UDS eBO Package	$1,438	Supports the electronic submission and reporting of Uniform Data System (UDS) metrics, enabling accurate tracking, monitoring, and evaluation of population health and value-based care initiatives.
PCMH Consultant	$8,000	Provides expert guidance and support to maintain Patient-Centered Medical Home recognition, ensuring adherence to quality standards, care coordination, and value-based care requirements.
PHVBC Training	$160,864	Supports staff education and skill-building to enhance capacity in population health management and value-based care, strengthening clinic performance and patient outcomes.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Nhan Hoa Comprehensive Health Care Clinic
Primary Contact Name and Title:	Jenny Nguyen CEO
Primary Contact Email and Phone Number:	jennyq.nguyen@nhanhoa.org 714-898-8888 x 123

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, Nhan Hoa Comprehensive Health Care Clinic will strengthen our care management infrastructure by (1) expanding Social Determinants of Health (SDOH) screening from 56% (1810/3239) to 65% of patients using PRAPARE and (2) utilizing responses to drive social service support connections for diabetic and hypertensive patients from 5% (14/269) to 25% of patients who request assistance by developing health education materials and expanding in-house/partnered ancillary support services such as transportation.	☐ Create additional culturally sensitive referral and community resource packages and educational materials in physical and digital formats. ☐ Host a health fair to connect patients with community resources. ☐ Embed SDOH Screening into other department check in processes, (e.g., optometry and pharmacy) . ☐ Provide transportation and food security assistance to diabetic and hypertensive patients.	☐ SDOH Screening rate, tracked quarterly (all eligible patients) ☐ Percent of diabetic and hypertensive patients connected to social supports (e.g., transportation), tracked quarterly
2. By June 2026, Nhan Hoa will decrease our diabetic A1c in poor control from 28% (423/1470) to 19% by expanding reminder calls and texts for labs, screenings, and follow-ups and increasing staff and patient engagement in health education and chronic care management.	☐ Increase frequency of text messages and calls to remind patients of A1C lab tests and follow-up appointments and overdue diabetic eye exams. ☐ Optimize patient education by streamlining clinic workflows to support patient education time, staff training, and improved consulting opportunities with other departments like pharmacy. ☐ Maintain pursuit list of patients to call or text for missing or expiring screenings.	☐ Diabetes in poor control (HbA1c >9), tracked quarterly (all eligible patients)

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3. By June 2026, Nhan Hoa will improve the percentage of our hypertensive patients with BP in good control from 80% (1935/2432) to 85%, by expanding reminder calls and texts for labs, screenings, and follow-ups and increasing staff and patient engagement in health education and chronic care management.	☐ Optimize patient education by streamlining clinic workflows to support patient education time, staff training, and improved consulting opportunities with other departments like pharmacy. ☐ Maintain pursuit list of patients to call or text for missing or expiring screenings.	☐ Blood Pressure in control (<140/90), tracked quarterly (all eligible patients)
4. By June 2026, Nhan Hoa will increase cervical cancer screening rate from 60% (1911/3281) to 65% by expanding reminder calls and texts for labs, screenings, and follow-ups, and creating project charters for obtaining approval for cervical cancer screening projects.	☐ Optimize patient education by streamlining clinic workflows to support patient education time, staff training, and improved consulting opportunities with other departments like pharmacy. ☐ Maintain pursuit list of patients to call or text for missing or expiring screenings. ☐ Create project charters for obtaining approval for self-collection cervical cancer screening tests.	☐ Cervical cancer screening rate, tracked quarterly (all eligible patients)

Line-Item Budget

Clinic Name: Nhan Hoa

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Carry Over	Year 4
Personnel			**Remaining Balance**
Executive Champion (.20 FTE)	38,601	-	38,601
Project Manager (.50 FTE)	35,724	-	35,724
QI/QA Lead (0.25 FTE)	38,662	-	38,662
IT Manager (0.25 FTE)	18,112	-	18,112
Provider Champion (.15 FTE)	47,596	-	47,596
Support Staff (.25 FTE)	26,250	-	26,250
		-	-
Subtotal	**204,945**	-	204,945
			-
Benefits (17.1%)	**35,056**	-	35,056
Total Personnel	**240,001**	-	240,001
Non-Personnel		-	-
Seminars	7,750		7,750
Space Saving Exam Tables (17 @2,800 each)	47,600	-	
Ergonmic Computer Wall Mounts (17 @ $1,450 each	24,650		
		-	
		-	-
		-	-
		-	-
		-	-
Total Non-Personnel	**80,000**	-	80,000
Subtotal Direct Costs	**320,001**	-	320,001
Indirect Costs @ 6%		-	-
TOTAL	**320,001**	-	320,001
Other Costs		-	-
Subcontracts/Consultants		-	-
Training	123,649	-	123,649
		-	-
		-	-
		-	-
		-	-
		-	-
Total Other Costs	**123,649**	-	123,649
		-	-
GRAND TOTAL	**443,650**	-	443,650

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Budget Justification Form- Nhan Hoa

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Specific Line-Item Notes:

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- *For any consultants, identify each unique consultant, the services he/she will perform and how the fees are calculated (e.g. rate of pay, per diem, travel costs, etc.).*
- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
Executive Champion (20% FTE)	$38,601	Supports team in navigating challenges
Project Manager (50% FTE)	$35,724	Project manager, meeting facilitator, data steward, lead efforts to strengthen data reporting efforts and ability to stratify data reports
QI/QA Lead	$38,662	Quality Improvement lead, back-up project management support, lead on strengthening partnerships with specialty partners
IT Manager (25% FTE)	$18,112	
Provider Champion (15% FTE)	$47,596	Lead on clinical quality measures improvement efforts, sharing updates and building engagement with other providers and with care teams
Support Staff	$26,250	Provides administrative and operational assistance to ensure smooth clinic workflows and effective implementation of

Line Item*	Amount	Justification
		population health and value-based care initiatives.
Benefits	$35,056	Supports employee health, retirement, and other standard benefits to retain staff and sustain population health and value-based care initiatives.
Seminars	$7,750	Supports participation in educational seminars to enhance staff knowledge, skills, and capacity in population health management and value-based care initiatives.
Space Saving Exam Tables (17 at a per unit price of $2,800)	$47,600	Supports the purchase of compact exam tables to optimize clinic space, improve patient flow, and enhance the delivery of population health and value-based care services.
Ergonomic Computer Wall Mounts (17 at a per unit price of $1,450 each)	$24,650	Supports installation of adjustable computer mounts to improve staff ergonomics, workflow efficiency, and effective use of electronic health records in population health and value-based care initiatives.
Training	$123,469	Supports staff development and skill-building to enhance capacity for implementing population health and value-based care initiatives effectively.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Obria Medical Clinics
Primary Contact Name and Title:	Pleshetta Dauzart Interim Executive Director, Chief Administrative Officer
Primary Contact Email and Phone Number:	pdauzart@obriagroup.org 949.273.5040

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, Obria Medical Clinics will increase its breast cancer screening rate from 30%to 70%, and its cervical cancer screening rate from 50% to 80%, through reconciliation of external records, standardization of care team workflows, and patient engagement strategies (education, reminders, and incentives).	☐ Optimize medical records reconciliation process to improve patient history/records and EHR documentation compliance. ☐ Document, train staff in, and implement cancer screening clinical care guidelines and pre-visit/huddle workflows to better engage patients in completing cancer screenings ☐ Use reminders (calls, texts, emails), education, and rewards (CalOptima $25 incentive, in-house “Baby Supplies Store” point system) to incentivize closing these cancer screening care gaps.	☐ Breast cancer screening rate tracked quarterly (all eligible patients). ☐ Cervical cancer screening rate, tracked quarterly (all eligible patients).
2. By June 2026, Obria Medical Clinics will reduce no-show rates from 60% to 40% and increase lab completion rates from 40% to 60% through enhanced patient reminders, simplified rescheduling, incentives, and in-house labs	☐ Implement dual reminder system (48-hour + 1-hour reminders) ☐ Design and implement a streamlined, stigma-free process for contacting patients who don’t show up for appointments and rescheduling them within 7 days of missed appointment. ☐ Launch patient incentive program for patients who show for their appointments on time ☐ Train staff in lab documentation processes (including patient refusals and waivers) ☐ Begin offering in-house lab options for patients.	☐ No Show rate, tracked quarterly (all eligible appointments) ☐ Lab Completion Rate, tracked quarterly (all eligible appointments)

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Line-Item Budget

Clinic Name: Obria Medical Clinics of Southern California Inc./OMC-Santa Ana

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Carry Over	Year 4
Personnel			
Executive Champion/Operation Lead (0.3 FTE)	$61,000	-	61,000
Project Manager/QI Lead (1.0 FTE)	$115,000	-	115,000
IT Champion/Data Reporting Lead (0.3 FTE)	$35,000	-	35,000
Clinic RN (0.1 > 0.2 FTE)	$25,000	-	25,000
		-	-
		-	-
		-	-
Subtotal	**236,000**	-	236,000
			-
Benefits (25%)	**59,000**	-	59,000
Total Personnel	**295,000**	-	295,000
Non-Personnel		-	-
IT/QI/Travel (non-personnel)	$6,887		6,887
		-	-
		-	-
		-	-
		-	-
Total Non-Personnel	**6,887**	-	6,887
Subtotal Direct Costs	**301,887**	-	301,887
Indirect Costs @ 6%	**18,113**	-	18,113
TOTAL	**320,000**	-	320,000
Other Costs		-	-
Subcontracts/Consultants		-	-
Training	$123,650	-	123,650
		-	-
		-	-
		-	-
		-	-
		-	-
Total Other Costs	**123,650**	-	123,650
		-	-
GRAND TOTAL	**443,650**	-	443,650

Indirects costs not to exceed 6%
Total requested budget will not exceed $250,000

Please insert the position title and the % FTE

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Budget Justification Form- Obria

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Specific Line-Item Notes:

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Line Item*	Amount	Justification
Executive Champion/Operations Lead (30% FTE)	$61,000	Provides leadership and operational oversight to guide initiative implementation, coordinate clinic activities, and ensure successful outcomes in population health and value-based care programs.
Project Manager/QI Lead (100% FTE)	$115,000	Oversees planning, coordination, and quality improvement initiatives to ensure effective implementation of population health and value-based care programs and achievement of program goals.
IT Champion/Data Reporting Lead (30% FTE)	$35,000	Provides leadership and expertise in data management, reporting, and analytics to support informed decision-making and effective implementation of population health and value-based care initiatives.
Clinic RN (10 – 20% FTE)	$25,000	Provides direct patient care, care coordination, and clinical support to advance population health management

Line Item*	Amount	Justification
		and value-based care initiatives, ensuring high-quality outcomes.
Benefits	$59,000	Supports employee health, retirement, and other standard benefits to retain staff and sustain population health and value-based care initiatives.
IT/QI/Travel (non-personnel)	$6,887	Supports technology, quality improvement activities, and staff travel necessary for effective implementation, data management, and monitoring of population health and value-based care initiatives.
Indirect Costs	$18,113	Supports administrative and operational expenses that enable effective management, oversight, and sustainability of population health and value-based care initiatives.
Training	$123,650	Supports staff education and skill-building to enhance capacity and effectiveness in implementing population health and value-based care initiatives.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Planned Parenthood of Orange and San Bernardino Counties/Melody Health
Primary Contact Name and Title:	Shannon Connolly, MD Associate Medical Director and Director of Primary Care
Primary Contact Email and Phone Number:	Shannon.Connolly@PPOSBC.org 714-922-4100 ext 105

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, PPOSBC/Melody Health will improve our Cervical Cancer Screening rate from 43% (3590/8307) to 48% through piloting self-collection HPV screenings and piloting CDSS alerts.	☐ Pilot Self-Collected Primary HPV Screening in three health centers to test proof of concept and patient acceptability, and develop clinical and operational workflows. Expand if proven successful. ☐ Pilot CDSS Alerts for Cervical Cancer Screening ☐ Troubleshoot significant data discrepancies between our internal reports and those of our health plan/IPA partners. Our internal data shows our screening rate to be 70.5% (4190/5947), significantly higher than our CalOptima and Optum data (43%, 3590/8307).	☐ Cervical cancer screening rate, tracked quarterly (all eligible patients)
2. By June 2026, PPOSBC/Melody Health will improve the percentage of diabetic patients who are in poor control (HbA1c >9) from 79.3% (265/334) to 74.3% through implementing a glycemic control in diabetes clinical rule engine (CRE) and through improved diabetes care management.	☐ Implement the Glycemic Control in Diabetes Clinical Rule Engine (CRE). This new CRE will automate the addition of the appropriate CPT II code to document glycemic control when A1C is measured in clinic via a point of care test ☐ Continue with efforts to build staff education around understanding/addressing patient barriers to care specific to diabetes; leverage point-of-care A1c testing to better engage patients in their diabetes care ☐ Troubleshoot significant data discrepancies between our internal reports and those of our health plan/IPA partners. Our internal data shows our diabetes in poor control rate to be 41% (279/685), significantly lower than our CalOptima and Optum data (79%, 265/334).	☐ Diabetes in poor control (HbA1c >9), tracked quarterly (all eligible patients)

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Line-Item Budget

Clinic Name: Planned Parenthood

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Year 4
Personnel		**Remaining Balance**
Assoc. Medical Director/Clinical Lead - .20 FTE	$47,500	47,500
Director of Case Management/Patient Nav. Lead - .20	$25,000	25,000
Informaticist Lead - .15 FTE	$20,000	20,000
Sr. Applications Manager/IT Lead - .10 FTE	$15,000	15,000
Sr. Director of Quality Management/QI support - .05 F	$5,000	5,000
Sr. Manager of Business Analytics/Data Reporting Le	$20,500	20,500
Clinicial Lead/Training and Quality Lead - .10 FTE	$15,500	
Patient Services Assoc. Director/Operations Lead - .2	$20,000	
Senior Payor Transformation Analyst/Payor Relations	20,000	20,000
Subtotal	**188,500**	188,500
		-
Benefits (25%)	**47,125**	47,125
Total Personnel	**235,625**	235,625
Non-Personnel		-
		-
		-
		-
		-
		-
Total Non-Personnel	-	-
Subtotal Direct Costs	**235,625**	235,625
Indirect Costs @ 6%		-
TOTAL	**235,625**	235,625
Other Costs		-
Subcontracts/Consultants		-
Office Supplies	$262	262
Training for population health management - 61 staff,	$54,000	54,000
Webinar: Data analytics training - 61 staff, two hours	$6,000	6,000
Webinar: self collected HPV screening - 61 staff, two	6,000	6,000
Consultant	141,763	141,763
		-
Total Other Costs	**208,025**	208,025
		-
GRAND TOTAL	**443,650**	443,650

Indirects costs not to exceed 6%

Total requested budget will not exceed $250,000

Please insert the position title and the % FTE

The benefit line item has a formula set for 25%. Please adjust to match your organization's standard benefit.

Indirect costs are set at 6%.

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Budget Justification Form- Planned Parenthood

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Specific Line-Item Notes:

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- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
Assoc. Medical Director/Clinical Lead (20% FTE)	$47,500	Executive champion, clinical lead, QI support
Director of Case Management/ Patient Nav. Lead (20% FTE)	$25,000	Case management and patient navigator lead, QI support
Informaticist Lead (15% FTE)	$20,000	Provides expertise in health data management, analytics, and reporting to support decision-making, population health management, and value-based care initiatives across clinics.
Sr. Applications Manager/IT Lead (10% FTE)	$15,000	Provides leadership and oversight for IT systems, applications, and infrastructure to ensure effective data management, workflow optimization, and support of population health and value-based care initiatives.

Line Item*	Amount	Justification
Sr. Director of Quality Management/QI Support (5% FTE)	$5,000	Provides leadership and oversight for quality improvement initiatives, guiding data-driven strategies and supporting clinics in achieving population health and value-based care goals.
Sr. Manager of Business Analytics/Data Reporting Lead (25% FTE)	$20,500	Data reporting lead
Clinical Lead/Training and Quality Lead (10% FTE)	$15,500	Provides clinical oversight, staff training, and quality improvement guidance to ensure effective implementation of population health and value-based care initiatives.
Patient Services Assoc. Director/Operations Lead (20% FTE)	$20,000	Provides operational leadership to implement and sustain population health and value-based care initiatives, building internal and clinic-level capacity while ensuring alignment across staff, consultants, and participating health centers.
Senior Payor Transformation Analyst/Payor Relations Lead (20% FTE)	$20,000	Payor relations lead, data reporting support
Benefits	$47,125	Covers the cost of employee health and other standard benefits necessary to recruit and retain skilled staff essential for implementing and sustaining population health and value-based care initiatives.
Office Supplies	$262	Supports day-to-day operations by providing necessary materials for staff to manage population health and value-based care activities, including documentation, reporting, and coordination across clinics and internal teams.
Training for population health management – 61 staff, 16 hours	$54,000	Funds staff participation in training and professional development to strengthen skills in population health strategies, data-driven care, and value-based care implementation across participating health centers.

Line Item*	Amount	Justification
Webinar: Data Analytics Training – 61 staff, 2 hours	$6,000	Supports staff participation in webinars to enhance data analytics skills for monitoring, reporting, and improving population health outcomes across participating health centers.
Webinar: Self-collected HPV screening – 61 staff, 2 hours	$6,000	Supports staff training on self-collected HPV screening techniques to improve cervical cancer prevention and enhance population health services across participating health centers.
PHVBC Consultant	$141,763	Provides expert guidance and technical assistance to participating health centers, supporting the implementation of population health and value-based care strategies, quality improvement initiatives, and staff capacity building.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Radiant Health Centers
Primary Contact Name and Title:	Dr. Tulika Singh Medical Director
Primary Contact Email and Phone Number:	tsingh@radianthealthcenters.org (949) 809-5715

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, Radiant Health Center will improve our cervical cancer screening rates from 26% (73/279) to 57% through focused efforts on pre-visit planning, expansion and increased awareness of the application of clinical protocols, and optimized use of data systems.	☐ Document, standardize and leverage protocols for CCS to support improved CCS screening population-wide. ☐ Improve pre-visit planning to identify all those patients who are due for a CCS – leveraging data systems and morning huddles multiple times per week. ☐ Refine and roll-out patient education materials (e.g., materials, scripts for talking with the patient) on the importance of completing cancer screenings ☐ Refine scheduling process to offer screening within the next available appointment.	☐ Cervical cancer screening rate, tracked quarterly (all eligible patients)
2. By June 2026, Radiant Health Center will improve depression screening rates from 56% (834/1522) to 70%, and improving follow-up within 30-days rates from 32% (487/1522) to 50%, through focused efforts on pre-visit planning, expansion and increased awareness of the application of clinical protocols and optimized use of data systems.	☐ Document the referral processes (both internal and external) for scheduling follow-ups for those patients who screen positive for depression ☐ Expand our provider and patient education materials regarding the importance of caring for their depression ☐ Optimize pre-visit planning to identify patients due for depression screening – leveraging data systems and morning huddles multiple times per week	☐ Depression screening and follow up rate, tracked quarterly (all eligible patients)

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3. By June 2026, Radiant Health Center will improve anal cancer screening rates from 4% (12/310) to 50% through focused efforts on pre-visit planning, development of patient and staff education materials, and optimized use of data systems.	☐ Optimize pre-visit planning and clinic workflows, including tracking within EHR, so promote completing the screening during the visit and/or scheduling a follow up appointment during the patient visit. ☐ Develop protocols, standing orders, and training guides to help staff adopt and implement this screening ☐ Develop, train on, and implement patient education and awareness strategies about the importance of this screening	☐ Anal cancer screening rate, tracked quarterly (all eligible patients)

Line-Item Budget

Clinic Name: Radiant

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Year 4
Personnel		**Remaining Balance**
Medical Director (16% FTE)-[redacted]	$44,880	44,880
Quality Compliance Manager (58% FTE)	$89,880	89,880
Data Analyst (70% FTE)	$57,240	57,240
		-
		-
		-
		-
Subtotal	**192,000**	192,000
		-
Benefits (25%)	**48,000**	48,000
Total Personnel	**240,000**	240,000
Non-Personnel		-
Staff Training and Support	$4,385	4,385
Patient Engagement & Education		-
Health IT Infrastructure	$12,500	12,500
Infrastructure & Facilities	15,000	15,000
Consultant PCMH	30,000	30,000
Total Non-Personnel	**61,885**	61,885
Subtotal Direct Costs	**301,885**	301,885
Indirect Costs @ 6%	**18,115**	18,115
TOTAL	**320,000**	320,000
Other Costs		-
Subcontracts/Consultants		-
PHVBC Training	$123,650	123,650
		-
		-
		-
		-
		-
Total Other Costs	**123,650**	123,650
		-
GRAND TOTAL	**443,650**	443,650

Indirects costs not to exceed 6%

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Budget Justification Form- Radiant

The budget justification is a narrative that explains and justifies the projected expenses attributed to each line item within a project budget and ties the budget to the proposed deliverables and scope of work. The narrative should explain both (1) how the expenses were calculated and (2) how they contribute to achieving the project objectives. Please include a concise narrative for each line item included in your proposed budget.

Specific Line-Item Notes:

- *For personnel, please list separately each position included in this budget, their annual salary (or hourly rate) and the percentage of time dedicated to the project.*
- *For any consultants, identify each unique consultant, the services he/she will perform and how the fees are calculated (e.g. rate of pay, per diem, travel costs, etc.).*
- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
Medical Director (16% FTE)	$44,880	Provides clinical leadership and oversight, guiding population health and value-based care strategies, ensuring quality improvement, and supporting staff and participating health centers in delivering evidence-based care.
Quality Compliance Manager (58% FTE)	$89,880	Oversees quality improvement and compliance activities, ensuring participating health centers meet regulatory standards, achieve population health goals, and successfully implement value-based care initiatives.
Data Analyst (70% FTE)	$57,240	Supports the initiative by collecting, analyzing, and reporting data to monitor population health outcomes, inform value-based care strategies, and guide quality improvement across participating health centers.
Benefits	$48,000	

Line Item*	Amount	Justification
Staff Training and Support	$4,385	Provides ongoing training, coaching, and resources to build staff capacity, enhance skills, and ensure effective implementation of population health and value-based care initiatives.
Health IT Infrastructure	$12,500	Supports the development and maintenance of electronic health records, data systems, and secure technology platforms essential for managing population health, reporting outcomes, and enabling value-based care across participating health centers.
Infrastructure and Facilities	$15,000	Covers costs for maintaining and upgrading clinic spaces and operational facilities to ensure a safe, functional, and efficient environment for delivering population health and value-based care services.
PCMH Consultant	$30,000	Provides expert guidance and technical assistance to participating health centers on Patient-Centered Medical Home (PCMH) transformation, supporting care model implementation, quality improvement, and value-based care readiness.
Indirect Costs	$18,115	Covers administrative and overhead expenses, including finance, human resources, and organizational support, necessary to sustain the management and successful implementation of population health and value-based care initiatives.
PHVBC Training	$123,650	Supports staff participation in population health and value-based care training to strengthen skills, enhance care delivery, and build capacity across participating health centers.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Share Ourselves
Primary Contact Name and Title:	Anna Tiongco Quality and Clinical Systems Director
Primary Contact Email and Phone Number:	ationgco@shareourselves.org 949.270.2105

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, Share Ourselves will improve our pediatric immunization rates, as demonstrated by improving CIS-Combo 10 form 3% (2/60) to 15% by implementing a pediatric-focused pre-visit planning process at the Children and Family Health Clinic (CFHC) site to proactively identify and close care gaps, enhance care coordination, and support patient and family engagement.	☐ Modifying the current chart prep checklist and workflow to align with the unique needs of the pediatric population. ☐ Training staff on pediatric-specific chart preparation and team huddle processes to ensure consistency and shared accountability. ☐ Incorporating patient and family education strategies to engage caregivers in understanding and supporting care goals. ☐ Continued spread and sustaining the pre-visit planning protocols, forms across more sites and more patient populations/conditions	☐ Childhood Immunization Status Combo 10, tracked quarterly (all eligible patients) ☐ Annual Well Child Visit % for three age ranges, (0-15 months, 15-30 months, 3y/o and older), tracked quarterly (all eligible patients)
2. By June 2026, Share Ourselves will improve our Annual Wellness Visit completion rate from 20% to 30% (N = 2,134) by establishing a team-based care and documentation optimization model at the Adams Clinic for Annual Wellness Visits (AWVs), promoting collaboration between Medical Assistants and providers to improve workflow efficiency, data quality, and overall patient experience.	☐ Improve the current AWV documentation process by enabling MAs to complete designated sections of the AWV template prior to the provider's portion, ensuring efficient use of time and comprehensive data capture. ☐ Continue to strengthen team based care models, updating scopes of practice and standard work for care team members empowering team members to work at top of their scope, streamlining visit flow and enhancing the patient experience. ☐ Incorporate patient incentives into patient engagement efforts	☐ Annual Wellness Visit completion rate, tracked quarterly (all eligible patients)

Commented [IHQC1]: Please update with %'s and numerator/denominator values

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	☐ Pilot at Adams site, spread to other sites over the course of the year	

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Line-Item Budget

Clinic Name: Share Ourselves

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Year 4
Personnel		**Remaining Balance**
Director of Quality (.15 FTE)	22,500	22,500
Director of Nursing/Nurse Supervisor(0.20 FTE)	25,000	25,000
EHR Specialist (0.10 FTE)	6,900	6,900
Medical Assistant-Costa Mesa Site (1.00 FTE)	37,700	37,700
Medical Assistant-Santa Ana Site (1.00 FTE)	37,700	37,700
Medical Assistant-Newport Beach Site (1.00 FTE)	37,700	37,700
Medical Assistant-Mission Viejo Site (1.00 FTE)	37,420	37,420
Subtotal	**204,920**	204,920
		-
Benefits (23.5%)	**45,080**	45,080
Total Personnel	**250,000**	250,000
Non-Personnel		-
Artera/Patient Messaging Cost	30,000	30,000
Patient Welcome Tablets	20,000	20,000
		-
		-
		-
Total Non-Personnel	**50,000**	50,000
Subtotal Direct Costs	**300,000**	300,000
Indirect Costs @ 6%		-
TOTAL	**300,000**	300,000
Other Costs		-
Subcontracts/Consultants		-
Staff Training	143,650	143,650
		-
		-
		-
		-
		-
Total Other Costs	**143,650**	143,650
		-
GRAND TOTAL	**443,650**	443,650

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Budget Justification Form- Share Our Selves

The budget justification is a narrative that explains and justifies the projected expenses attributed to each line item within a project budget and ties the budget to the proposed deliverables and scope of work. The narrative should explain both (1) how the expenses were calculated and (2) how they contribute to achieving the project objectives. Please include a concise narrative for each line item included in your proposed budget.

Specific Line-Item Notes:

- *For personnel, please list separately each position included in this budget, their annual salary (or hourly rate) and the percentage of time dedicated to the project.*
- *For any consultants, identify each unique consultant, the services he/she will perform and how the fees are calculated (e.g. rate of pay, per diem, travel costs, etc.).*
- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
Director of Quality (.15 FTE)	22,500	Provides leadership and oversight for quality improvement initiatives, ensuring participating health centers meet population health goals, regulatory standards, and value-based care benchmarks.
Director of Nursing/Nurse Supervisor(0.20 FTE)	25,000	Provides clinical leadership and oversight for nursing staff, ensuring high-quality patient care, effective population health program implementation, and adherence to value-based care standards across participating health centers.
EHR Specialist (0.10 FTE)	6,900	Supports the management, optimization, and maintenance of electronic health record systems to ensure accurate data capture, reporting, and analysis for population health and value-based care initiatives.

Line Item*	Amount	Justification
Medical Assistant-Costa Mesa Site (1.00 FTE)	37,700	Provides direct patient care support, assists with clinical workflows, and ensures efficient implementation of population health and value-based care service.
Medical Assistant-Santa Ana Site (1.00 FTE)	37,700	Provides direct patient care support, assists with clinical workflows, and ensures efficient implementation of population health and value-based care service.
Medical Assistant-Newport Beach Site (1.00 FTE)	37,700	Provides direct patient care support, assists with clinical workflows, and ensures efficient implementation of population health and value-based care service.
Medical Assistant-Mission Viejo Site (1.00 FTE)	37,420	Provides direct patient care support, assists with clinical workflows, and ensures efficient implementation of population health and value-based care service.
Benefits (23.5%)	**45,080**	Covers employee health and other standard benefits.
Artera/Patient Messaging Cost	30,000	Supports the use of secure patient messaging and communication platforms to enhance patient engagement, care coordination, and follow-up for population health and value-based care initiatives.
Patient Welcome Tablets	20,000	Provides tablets for patient check-in and education, streamlining clinic workflows and supporting engagement in population health and value-based care initiatives.
Staff Training	143,650	Supports professional development and educational opportunities to enhance staff skills, improve care delivery, and support the successful implementation of population health and value-based care initiatives.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Serve the People Community Health Center
Primary Contact Name and Title:	Beatriz Becerra QA & Business Manager
Primary Contact Email and Phone Number:	bbecerra@servethepeoplechc.org (714)-352-2911 Ext: 1109

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 30, 2026, reduce the proportion of diabetic patients with A1c >9 from 30% (403/1,341) to 27% (363/1,341) by implementing targeted outreach, pharmacist co-visits, medication reviews, and adherence support — supporting diabetic patients to complete at least one pharmacist co-visit and receive documented medication counseling.	☐ Develop and implement pharmacist co-visits with patients, starting one day/week, where patients will receive enhanced medication review, adherence counseling, and education materials ☐ Generate risk-stratified diabetic population report and develop targeted outreach list/strategy. ☐ Monitor patient participation; identify barriers; adjust outreach strategies; track interim A1c results quarterly	☐ Diabetes in poor control (A1c >9), tracked quarterly (all eligible patients)
2. By June 30, 2026, increase cervical cancer screening rate from 50% to 55% (from 1,127 to at least 1,251 patients) by running three Pap days per month (≈75 scheduled screenings), expanding with Optum's roaming program, implementing robust outreach and no-show mitigation, and continuously monitoring quality dashboards.	☐ Launch Well-Woman/Pap Days, with three dedicated days per month where a providers schedule will be dedicated to well women exams. ☐ Expand outreach and care coordination efforts to support well-women/pap days – supported by care coordinators to support text, calls, and transportation supports. ☐ Schedule Optum roaming program days as available; ☐ Actively manage and monitor program - run monthly huddles using dashboards; adjust outreach strategy based on no-show and attendance data	☐ Cervical Cancer Screening Rate, tracked quarterly (all eligible patients)

Commented [IHQC1]: Like we referenced in your work plan feedback, consider adjusting this to a realistic and attainable goal (maybe something closer to where you close the 2024 year at - 26%

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3. By June 30, 2026, increase colorectal cancer screening from 40% (1,138/2,865) to 45% (1,290/2,865) by leveraging Exact Sciences collaboration to provide clear patient instructions, phone assistance, and reminder messages — reducing staff workload, improving test completion, and boosting overall screening efficiency.	☐ Finalize patient eligibility list ☐ Collaborate with Exact sciences to optimize patient instructions, patient communications, and program monitoring ☐ Train staff in new patient engagement strategies and education materials. ☐ Actively manage and monitor project: Monthly huddles to review kit return rates and patient outreach; test additional reminder methods (text or robocalls); address barriers (language, transportation) ☐ Maintain ongoing mailing and reminder workflows with Exact Sciences; develop sustainability plan and SOPs	☐ Colorectal cancer screening rate, tracked quarterly (all eligible patients)

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Line-Item Budget

Clinic Name: Serve the People Community Health Center

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Year 4
Personnel		**Remaining Balance**
Executive Director (5%FTE)	13,000	13,000
CMO (15%FTE)	52,392	52,392
Quality Programs Specialist (20%)	23,600	23,600
Health Center Operations Manager (10%FTE)	9,150	9,150
Business Office Manager (5%FTE)	5,750	5,750
Population Health Program Coordinator (100%FTE)	65,000	65,000
Care Team Facilitator (100%FTE)	49,920	
Resource Care Coordinator (75%FTE)	32,760	
		-
Subtotal	**251,572**	251,572
		-
Benefits (20%)	**50,314**	50,314
Total Personnel	**301,886**	301,886
Non-Personnel		-
		-
		-
		-
		-
		-
Total Non-Personnel	**-**	-
Subtotal Direct Costs	**301,886**	301,886
Indirect Costs @ 6%	**18,113**	18,113
TOTAL	**319,999**	319,999
Other Costs		-
Subcontracts/Consultants		-
PHVBC Training	$123,651	123,651
		-
		-
		-
		-
		-
Total Other Costs	**123,651**	123,651
		-
GRAND TOTAL	**443,650**	443,650

Indirects costs not to exceed 6%

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Budget Justification Form- Serve the People

The budget justification is a narrative that explains and justifies the projected expenses attributed to each line item within a project budget and ties the budget to the proposed deliverables and scope of work. The narrative should explain both (1) how the expenses were calculated and (2) how they contribute to achieving the project objectives. Please include a concise narrative for each line item included in your proposed budget.

Specific Line-Item Notes:

- *For personnel, please list separately each position included in this budget, their annual salary (or hourly rate) and the percentage of time dedicated to the project.*
- *For any consultants, identify each unique consultant, the services he/she will perform and how the fees are calculated (e.g. rate of pay, per diem, travel costs, etc.).*
- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
Executive Director (5% FTE)	$13,000	Executive champion and project director
CMO (15% FTE)	$52,392	Provides strategic clinical leadership, guiding population health and value-based care initiatives, ensuring high-quality care delivery, and supporting participating health centers in achieving measurable health outcomes.
Quality Programs Specialists (20% FTE)	$23,600	Support participating health centers by implementing quality improvement initiatives, monitoring performance metrics, and ensuring compliance with population health and value-based care standards.
Health Center Operations Manager (10% FTE)	$9,150	Provides operational leadership and coordination across participating clinics, ensuring efficient workflows, resource allocation, and effective implementation of

Line Item*	Amount	Justification
		population health and value-based care initiatives.
Business Office Manager (5% FTE)	$5,750	Project manager, meeting facilitator, data steward, lead on strengthening partnerships with specialty partners
Population Health Program Coordinator (100% FTE)	$65,000	Supports the planning, implementation, and monitoring of population health initiatives, facilitating care coordination, data tracking, and quality improvement across participating health centers.
Care Team Facilitator (100% FTE)	$49,920	Supports care coordination and team-based workflows, helping staff implement population health and value-based care strategies to improve patient outcomes across participating health centers.
Resource Care Coordinator (75% FTE)	$32,760	Collaborates with Project Manager to develop partnerships with local CBOs/Social Services organizations
Benefits	$50,314	Covers employee health and other standard benefits.
Indirect Costs	$18,113	Covers administrative and overhead expenses, including finance, human resources, and organizational support, necessary to sustain the management and successful implementation of population health and value-based care initiatives.
PHVBC Training	$123,651	Supports staff participation in population health and value-based care training to strengthen skills, enhance care delivery, and build capacity across participating health centers.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Sierra Health Center
Primary Contact Name and Title:	Kathleen Gonzalez Executive Director
Primary Contact Email and Phone Number:	Kgonzalez@shcenter.org 714-870-0717

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 30, 2026, Sierra Health Center will improve our cervical cancer screening rate from 40%% (2412/6000) to 57% through focused outreach, and active tracking of care gaps.	☐ Expanded patient outreach leveraging multiple patient lists (insurance plans, CQM, EHR) to improve chances of contacting patients. ☐ Standardize processes for tracking, monitoring results, and following up with patients following cervical and breast cancer screening. ☐ Obtain external Pap results from other providers and health plans to close care gaps ☐ Report monthly progress to leadership and use data to guide targeted interventions	☐ Cervical cancer screening rate, tracked quarterly (all eligible patients)
2. By June 30, 2026, Sierra Health Center will improve our colorectal cancer screening 37% (328/915) to 40% through focused outreach, expanded monitoring systems for tracking kit completion and abnormal follow up, and testing bulk orders for FIT kits for noncompliant patients.	☐ Distributing bulk orders of FIT kits using non-compliance lists provided by health insurance plans to reach patients overdue for colorectal cancer screening. ☐ Expanding the use of a tracking system to monitor colorectal screening status and abnormal results follow-up. Best practices developed here will be scaled up and spread to other departments and screenings. ☐ Implement phone outreach and reminder calls for patients overdue for screening ☐ Generate regular reports to assess progress and inform quality improvement strategies	☐ Colorectal cancer screening rates, tracked quarterly (all eligible patients)

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Line-Item Budget

Clinic Name: Sierra Health Center

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Carry Over	Year 4
Personnel			**Remaining Balance**
Project Oversight	34,320	-	34,320
QIA Care Coordinator / Case Management	11,960	-	11,960
QIA Support Family / Pediatrics	9,030	-	9,030
QIA Support OB-GYN	9,510	-	9,510
QIA Support Admin	23,650	-	23,650
Medical Director / Provider	55,000	-	55,000
QIA Liaison/ Data Analyst	40,040		
Provider	38,451		
Provider	35,000	-	35,000
Subtotal	**256,961**	-	256,961
			-
Benefits (25%)	**36,696**	-	36,696
Total Personnel	**293,657**	-	293,657
Non-Personnel		-	-
EMR Data and Reporting Integration	$8,000		8,000
		-	-
		-	-
		-	-
		-	-
Total Non-Personnel	**8,000**	-	8,000
Subtotal Direct Costs	**301,657**	-	301,657
Indirect Costs @ 6%	**18,343**	-	18,343
TOTAL	**320,000**	-	320,000
Other Costs		-	-
Subcontracts/Consultants		-	-
PHVBC Training	$123,650	-	123,650
		-	-
		-	-
		-	-
		-	-
		-	-
Total Other Costs	**123,650**	-	123,650
		-	-
GRAND TOTAL	**443,650**	-	443,650

Indirects costs not to exceed 6%

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Budget Justification Form- Sierra

The budget justification is a narrative that explains and justifies the projected expenses attributed to each line item within a project budget and ties the budget to the proposed deliverables and scope of work. The narrative should explain both (1) how the expenses were calculated and (2) how they contribute to achieving the project objectives. Please include a concise narrative for each line item included in your proposed budget.

Specific Line-Item Notes:

- *For personnel, please list separately each position included in this budget, their annual salary (or hourly rate) and the percentage of time dedicated to the project.*
- *For any consultants, identify each unique consultant, the services he/she will perform and how the fees are calculated (e.g. rate of pay, per diem, travel costs, etc.).*
- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
Project Oversight	34,320	Provides leadership and coordination to ensure effective implementation, monitoring, and evaluation of population health and value-based care initiatives across participating health centers.
QIA Care Coordinator / Case Management	11,960	Supports care coordination and case management activities to improve patient outcomes, enhance population health, and ensure successful implementation of value-based care initiatives across participating health centers.
QIA Support Family / Pediatrics	9,030	Provides targeted quality improvement support for family and pediatric care, helping clinics implement population health strategies and value-based care practices to improve patient outcomes.
QIA Support OB-GYN	9,510	Provides focused quality improvement support for obstetrics and gynecology services, assisting clinics in implementing

Line Item*	Amount	Justification
		population health strategies and value-based care practices to enhance patient outcomes.
QIA Support Admin	23,650	Provides administrative support for quality improvement activities, ensuring efficient coordination, documentation, and implementation of population health and value-based care initiatives across participating health centers.
Medical Director / Provider	55,000	Provides clinical leadership and direct patient care, guiding the implementation of population health and value-based care initiatives while ensuring high-quality, evidence-based care across participating health centers.
QIA Liaison/ Data Analyst	40,040	Supports data collection, analysis, and reporting while serving as a liaison between clinics and quality improvement teams to ensure effective implementation of population health and value-based care initiatives.
Provider	38,451	Delivers direct patient care while supporting the implementation of population health and value-based care initiatives to improve health outcomes across participating health centers.
Provider	35,000	Delivers direct patient care while supporting the implementation of population health and value-based care initiatives to improve health outcomes across participating health centers.
EMR Data and Reporting Integration	$8,000	Supports the integration, management, and reporting of electronic medical record data to enable accurate tracking, analysis, and improvement of population health and value-based care outcomes.
Indirect Costs @ 6%	**18,343**	Covers administrative and overhead expenses, including finance, human resources, and organizational support, necessary to sustain the management and successful implementation of population health and value-based care initiatives.
PHVBC Training	$123,650	Supports staff participation in population health and value-based care training to enhance knowledge, skills, and capacity for

Line Item*	Amount	Justification
		effective implementation across participating health centers.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Southland Integrated Services, Inc
Primary Contact Name and Title:	Tricia Nguyen CEO
Primary Contact Email and Phone Number:	tnguyen@southlandintegrated.org (714) 620-7007

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, Southland Integrated Services will improve the percentage of diabetic patients in poor control (HbA1c >9) form 23% (133/589) to 20% through utilizing and optimizing HIT strategies, increasing patient engagement through wellness days/education/health fairs and community partnerships.	☐ Develop Facilitate more education workshops, including group visits, and leverage partnerships with CalOptima ☐ Tracking lab orders for all non-compliant patients to ensure labs are ordered quarterly ☐ Streamline referrals to case management and refine diabetes-related standing orders. ☐ Expand use of HIT related supports, including scribing supports and remote patient monitoring.	☐ Diabetes in poor control (A1c >9), tracked quarterly (all eligible patients)
2. By June 2026, Southland Integrated Services will improve the completion rate for initial health appointments from 0% (most recent quarter - 0/49) to 10%, and reducing the overall % of patients who could be classified as assigned but unseen, through utilizing and optimizing HIT strategies, increasing patient engagement through wellness days/education/health fairs and community partnerships.	☐ Pull monthly IHA to establish care for newly assigned patients ☐ Continue outreaching to previously assigned but unseen patients to establish first appointment ☐ Start a referral program to potentially provide incentives to patients who refer other patients ☐ Expand the use of HIT related supports like Healow.	☐ Initial Health Appointment completion rate, tracked quarterly (all eligible patients)

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Line-Item Budget

Clinic Name: Southland Integrated Services

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Carry Over	Year 4
Personnel			**Remaining Balance**
Clinic Manager	99,815	-	99,815
Program Director	126,926	-	126,926
		-	-
		-	-
		-	-
		-	-
		-	-
Subtotal	**226,741**	-	226,741
			-
Benefits (21.5%)	**43,285**	-	43,285
Total Personnel	**270,026**	-	270,026
Non-Personnel		-	-
Supplies, at least 3 conferences (flight, lodging,	31,005		31,005
		-	
		-	
		-	-
		-	-
		-	-
		-	-
Total Non-Personnel	**31,005**	-	31,005
Subtotal Direct Costs	**301,031**	-	301,031
Indirect Costs @ 6%	**18,113**	-	18,113
TOTAL	**319,144**	-	319,144
Other Costs		-	-
Subcontracts/Consultants		-	-
Training	124,506	-	124,506
		-	-
		-	-
		-	-
		-	-
		-	-
Total Other Costs	**124,506**	-	124,506
		-	-
GRAND TOTAL	**443,650**	-	443,650

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Budget Justification Form-Southland Integrated

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Specific Line-Item Notes:

- *For personnel, please list separately each position included in this budget, their annual salary (or hourly rate) and the percentage of time dedicated to the project.*
- *For any consultants, identify each unique consultant, the services he/she will perform and how the fees are calculated (e.g. rate of pay, per diem, travel costs, etc.).*
- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
Clinic Manager	99,815	Provides operational leadership and oversight of clinic activities, ensuring efficient workflows, staff coordination, and effective implementation of population health and value-based care initiatives.
Program Director	126,926	Provides strategic leadership and oversight for population health and value-based care initiatives, coordinating staff, resources, and participating health centers to achieve program goals and improve patient outcomes.
Benefits (21.5%)	**43,285**	Covers employee health and other standard benefits necessary to recruit and retain staff essential for leading and supporting population health and value-based care initiatives.
Outreach, Educational, office, and program Supplies, at least 3 conferences (flight, lodging, Car rental, meals, other	31,005	Supports materials and resources for patient outreach, staff education, and program operations, as well as travel and participation costs for at least three conferences (including flights, lodging, car rental, meals, and related

Line Item*	Amount	Justification
misc. expenses rated to Conferences)		expenses) to build staff capacity and advance population health and value-based care initiatives.
Training	124,506	Supports staff development and educational opportunities to enhance skills, strengthen capacity, and support the effective implementation of population health and value-based care initiatives across participating health centers- building organizational capacity.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	St. Jude Neighborhood Health
Primary Contact Name and Title:	Mary Devlin Population Health Supervisor
Primary Contact Email and Phone Number:	Mary.devlin@providence.org 760-946-8151

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 2026, St. Jude Neighborhood Health Clinic will improve colorectal cancer screening rates form 47% (4,267/9,066) to 55% through standing orders, standard work, and new partnership with Exact Sciences.	☐ Implement partnership with Exact Sciences, the manufacturer of Cologuard, to receive the test results directly into EPIC. ☐ Expand Standing orders and standard work ☐ Staff will be trained in standing orders and standard work	☐ Colorectal Cancer screening rate, tracked quarterly (Fullerton Clinic Patients)
2. By June 2026, St. Jude Neighborhood Health Clinic will improve the percentage of diabetic patients in poor control (HbA1c >9) from 28% (1,419/4,982) to 25% through expanded staff engagement in chart review processes, provider scorecards, and Promotora training and patient education in diabetes health management and education approaches.	☐ Diabetes and Obesity Committee members will conduct quarterly chart audits to assess care team adherence to diabetes clinical care delivery protocols ☐ American Diabetes Association guidelines will be reviewed and incorporated into a standardized way of documenting diabetes counseling and care. ☐ Promotoras will be trained on topics relevant to diabetes care and prevention, and they will begin educating diabetic and prediabetic patients. ☐ Refresher training will be held for caregivers to review the standard order for POC A1c tests, and caregivers will be reminded where they can find all standing orders and standard work in the chosen platform.	☐ Diabetes in poor control (A1c >9), tracked quarterly (Fullerton Clinic Patients)

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3. By June 30, 2026, St. Jude Neighborhood Health Clinic will improve the percent of obese patients that have been given nutrition or physical activity counseling from 66% (994/1,873) to 75% through standardized documentation, staff training, and site competitions.	☐ Standardize documentation of counseling and care for obese patients. This will include the creation of smart phrases and identifying the correct diagnosis codes for conditions and care. ☐ Providers and back office staff will be trained on how to internally refer obese patients to our Registered Dietitian for nutrition and/or physical activity counseling. ☐ Friendly competition between providers or clinics during one quarter will help promote increased nutrition/physical activity counseling	☐ Obese Patients (BMI >30)who have received nutrition or physical activity counseling, tracked quarterly (Fullerton Clinic Patients)

Line-Item Budget

Clinic Name: St. Jude Neighborhood Health Center

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Carry Over	Year 4
Personnel			
Quality Manager (1.0 FTE)	90,000	-	90,000
Chief Quality Officer (0.2 FTE)	42,000	-	42,000
Data Analyst (0.1 FTE)	10,400	-	10,400
Physician Champion (0.05 FTE)	12,000	-	12,000
Care Coordination Supervisor (0.05 FTE)	5,000	-	5,000
		-	-
		-	-
Subtotal	**159,400**	-	159,400
			-
Benefits (25%)	**40,000**	-	40,000
Total Personnel	**199,400**	-	199,400
Non-Personnel		-	-
			-
		-	-
		-	-
		-	-
		-	-
Total Non-Personnel	-	-	-
Subtotal Direct Costs		-	-
Indirect Costs @ 6%		-	-
TOTAL	-	-	-
Other Costs		-	-
Subcontracts/Consultants		-	-
PHVBC Training	$126,970	-	126,970
RN Care Manager	0	-	-
Technology Enhancement	117,280.00	-	117,280
		-	-
		-	-
		-	-
Total Other Costs	**244,250**	-	244,250
		-	-
GRAND TOTAL	**443,650**	-	443,650

Indirects costs not to exceed 6%

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Budget Justification Form-St. Jude

The budget justification is a narrative that explains and justifies the projected expenses attributed to each line item within a project budget and ties the budget to the proposed deliverables and scope of work. The narrative should explain both (1) how the expenses were calculated and (2) how they contribute to achieving the project objectives. Please include a concise narrative for each line item included in your proposed budget.

Specific Line-Item Notes:

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Line Item*	Amount	Justification
Quality Manager (1.0 FTE)	90,000	Provides oversight and leadership for quality improvement initiatives, ensuring participating health centers meet population health goals, regulatory requirements, and value-based care standards.
Chief Quality Officer (0.2 FTE)	42,000	Provides executive leadership and strategic oversight for quality improvement and population health initiatives, ensuring participating health centers achieve value-based care goals and maintain regulatory compliance.
Data Analyst (0.1 FTE)	10,400	Collects, analyzes, and reports data to support population health management, monitor outcomes, and guide quality improvement and value-based care initiatives across participating health centers.
Physician Champion (0.05 FTE)	12,000	Provides clinical leadership and advocacy within participating health centers, promoting adoption of population health and value-based care practices and supporting quality improvement initiatives.

Line Item*	Amount	Justification
Benefits (25%)	**40,000**	Covers employee health and other standard benefits.
PHVBC Training	$126,970	Supports staff participation in population health and value-based care training to build knowledge, enhance skills, and strengthen capacity for effective implementation across participating health centers.
Technology Enhancement	117,280.00	Supports the optimization of technology systems and tools to improve data management, care coordination, and the implementation of population health and value-based care initiatives.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	St. Youstina Community Health Center
Primary Contact Name and Title:	Miriam Salazar Project Manager
Primary Contact Email and Phone Number:	miriam@lapizconsulting.org 951-751-2987

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 30, 2026, Saint Youstina Community Health Center will increase the percentage of hypertensive patients with BP under control from 55% (194/350) to 63% and decrease the percentage of diabetic patients with A1c in poor control from 54% (135/252) to 47%. This will be accomplished by implementing structured care coordination workflows, including standardized ECW documentation templates, monthly patient outreach based on care gap reports, and targeted staff retraining on accurate clinical documentation and measure requirements.	☐ Finalize and implement chronic care templates in ECW for diabetes and hypertension to improve structured documentation. ☐ Initiate monthly outreach to patients with care gaps using ECW reports. ☐ Conduct staff trainings on ECW usage, HEDIS documentation, and use of templates ☐ Pilot and scale up chronic care management protocols, including daily huddles, pre-visit planning, medication management, and proactive patient follow-up.	☐ Diabetes in poor control (A1c >9), tracked quarterly (all eligible patients). ☐ Blood pressure in control (<140/90) , tracked quarterly (all eligible patients).
2. By June 30, 2026, Saint Youstina Community Health Center will improve patient access by decreasing no show rates by 8% and increasing the percentage of no show appointments that were rescheduled within 7 days by 10%. This will be accomplished by implementing standardized communication handoff workflows, enhancing patient outreach with multi-channel reminders, and providing targeted EHR training to staff.	☐ Implement standardized handoff workflow between outreach, scheduling, and clinical teams ☐ Launch multi-channel patient reminder system (phone, text, mail) targeting patients with upcoming appointments ☐ Train staff in streamlined EHR documentation strategies and communication tools	☐ No Show rate, tracked monthly (all eligible appointments) ☐ Rescheduling rate for no show appointments (all eligible appointments)

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Line-Item Budget

Clinic Name: St. Youstina

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Carry Over	Year 4
Personnel			
1) CMO (5%FTE)	13,750	-	13,750
2) CFO (5%FTE)	10,000	-	10,000
3) Front Desk (20% FTE)	22,750	-	22,750
4) Front Desk (20% FTE)	22,750	-	22,750
5) Nurse Practitioner (10% FTE)	18,500	-	18,500
6) Medical Assistant (10% FTE)	5,200	-	5,200
7) QI/QA Coordinator (50% FTE)	65,000	-	65,000
8) Patient Care Coordinator (25% FTE)	16,250		
9) Outrech Coordinator (50% FTE)	47,321		
Subtotal	**221,521**	-	221,521
			-
Benefits (12%)	**26,583**	-	26,583
Total Personnel	**248,104**	-	248,104
Non-Personnel		-	-
Rent and Utilities	23,896		23,896
Patient Education Materials Printed in English/Spanis	13,000	-	13,000
Equipment - 3 Laptops and Software to support Population Health Management	12,000	-	12,000
Training for staff to support program goals	23,000	-	23,000
		-	-
Total Non-Personnel	**71,896**	-	71,896
Subtotal Direct Costs	**320,000**	-	320,000
Indirect Costs @ 0%	**-**	-	-
TOTAL	**320,000**	-	320,000
Other Costs		-	-
Subcontracts/Consultants		-	-
Consultants	123,650	-	123,650
		-	-
		-	-
		-	-
		-	-
		-	-
Total Other Costs	**123,650**	-	123,650
		-	-
GRAND TOTAL	**443,650**	-	443,650

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Budget Justification Form-St. Youstina

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Specific Line-Item Notes:

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Line Item*	Amount	Justification
CMO (5%FTE)	13,750	Provides strategic clinical leadership, guiding population health and value-based care initiatives, ensuring high-quality care delivery, and supporting participating health centers in achieving measurable health outcomes.
CFO (5%FTE)	10,000	Provides financial leadership and oversight, ensuring effective budget management, resource allocation, and fiscal sustainability to support population health and value-based care initiatives across participating health centers.
Front Desk (20% FTE)	22,750	Supports patient intake, scheduling, and administrative coordination to ensure smooth clinic operations and effective delivery of population health and value-based care services.
Front Desk (20% FTE)	22,750	Supports patient intake, scheduling, and administrative coordination to ensure smooth clinic operations and effective delivery of population health and value-based care services.

Line Item*	Amount	Justification
Nurse Practitioner (10% FTE)	18,500	Provides direct patient care, preventive services, and care management while supporting the implementation of population health and value-based care initiatives to improve health outcomes across participating health centers.
Medical Assistant (10% FTE)	5,200	Provides clinical support, assists with patient care workflows, and helps implement population health and value-based care initiatives to ensure efficient and high-quality service delivery across participating health centers.
QI/QA Coordinator (50% FTE)	65,000	Supports quality improvement and assurance activities by monitoring performance metrics, facilitating care interventions, and ensuring adherence to population health and value-based care standards across participating health centers.
Patient Care Coordinator (25% FTE)	16,250	facilitates care coordination, patient engagement, and follow-up services to improve health outcomes and support the implementation of population health and value-based care initiatives across participating health centers.
Outreach Coordinator (50% FTE)	47,321	Leads patient and community outreach efforts, promoting engagement, education, and access to services to support population health and value-based care initiatives across participating health centers.
Benefits (12%)	**26,583**	Covers employee health, and other standard benefits.
Rent and Utilities	23,896	Covers the costs of clinic and office space, including utilities, necessary to maintain a safe, functional, and efficient environment for delivering population health and value-based care services.
Patient Education Materials Printed in English/Spanish	13,000	Supports the development and distribution of bilingual educational materials to improve health literacy, patient engagement, and outcomes within population health and value-based care initiatives.

Line Item*	Amount	Justification
Equipment - 3 Laptops and Software to support Population Health Management	12,000	Provides essential hardware and software to enable staff to manage data, track outcomes, and implement population health and value-based care initiatives efficiently across participating health centers.
Consultants	123,650	Provides expert guidance and technical assistance to support the implementation, monitoring, and optimization of population health and value-based care initiatives across participating health centers.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	UCI Health - Family Health Center
Primary Contact Name and Title:	Anna Peña RN QI Administrator, Practice Care Manager Pediatrics & OB/GYN, Integrative Medicine.
Primary Contact Email and Phone Number:	apena11@hs.uci.edu ~~714-480-3501~~ 949-966-8100

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PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 30, 2026, UCI Health will increase Breast Cancer Screening (BCS) rates for eligible unique patients from 65.54% (2571/3923) to 68.54% though improved care coordination, streamlined clinic workflows, and continuing to nurture provider and patient engagement and interactions. Additionally, we will improve the current tracking system to identify and follow up with unscreened patients.	☐ Expand mobile mammography events and women wellness events to proactively address and close multiple preventative care gaps through bundled service delivery. ☐ Increase targeted Artera text message campaigns to remind eligible patients to schedule mammograms and offer direct scheduling support from the population health team. ☐ Develop and implement a workflow allowing Population Health to directly schedule patients referred to internal UCI health screening resources.	☐ Breast cancer screening rate, tracked quarterly (all eligible patients)
2. By June 2026, increase Depression Screening and follow up rates among eligible patients from 67.55% to 69.55% (a 2% increase) by implementing quality improvement workflows that consist of standardize process for warm handoffs or referrals to LCSW's, MAT team, internal mental health clinic, referrals to external community mental health	☐ Engaging practice leaders in holding staff accountable for completing the screening process and ensuring staff are equipped with the tools to complete this. ☐ Continuous process improvement with patient rooming process to help increase completion and gain staff cooperation on encouraging patients to complete screening. ☐ Increase MyChart enrollment and electronic screening- Patients will have the option to complete the screening prior to their	☐ Depression screening and follow up rate, tracked quarterly (all eligible patients)

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resources, and leveraging the Registered Nurse team through telemedicine outreach and in-clinic nurse visits.	appointment, and if not completed upon check in, staff will have a second opportunity to capture the screening. ☐ Standardize process for warm handoffs or referrals to LCSW's, MAT team, and other support services.	

Line-Item Budget

Clinic Name: UCI

Proposal Title: 2025-2026 Population Health and Transition to Value Base

Proposal Expenses	Budget Year 4	Carry Over
Personnel		
Community Health Educator (100%FTE)	**74,610.00**	
Medical Assistant (100%FTE)	**62,566.00**	
Medical Assistant (100%FTE)	**56,722.00**	
Medical Assistant (55%FTE)	**29,879.00**	
Subtotal	**223,777.00**	
Benefits (43%)	**96,224.00**	
Total Personnel	**320,001.00**	
Non-Personnel		
Total Non-Personnel	**-**	
Subtotal Direct Costs	**320,001.00**	
Indirect Costs @ 6%		
TOTAL	**320,001.00**	
Other Costs		
Subcontracts/Consultants		
PHVBC Training	123,649.00	
Total Other Costs	**123,649.00**	
GRAND TOTAL	**443,650.00**	

Indirects costs not to exceed 6%

Please insert the position title and the % FTE

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Budget Justification Form-UCI

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Line Item*	Amount	Justification
Community Health Educator (100%FTE)	**74,610.00**	Provides education, outreach, and engagement to patients and communities to promote preventive care, health literacy, and improved outcomes within population health and value-based care initiatives.
Medical Assistant (100%FTE)	**62,566.00**	Provides clinical and administrative support, assisting with patient care, workflow management, and the implementation of population health and value-based care initiatives across participating health centers.
Medical Assistant (100%FTE)	**56,722.00**	Provides clinical and administrative support, assisting with patient care, workflow management, and the implementation of population health and value-based care initiatives across participating health centers.
Medical Assistant (55%FTE)	**29,879.00**	Provides clinical and administrative support, assisting with patient care, workflow management, and the implementation of population health and value-based care initiatives across participating health centers.

Line Item*	Amount	Justification
Benefits (43%)	**96,224.00**	Covers employee health and other standard benefits.
PHVBC Training	123,649.00	Supports staff participation in advanced population health and value-based care training beyond initiative-specific sessions to build deeper expertise, enhance skills, and strengthen capacity across participating health centers.

*add more rows, as needed.

Impact Objectives / Scope of Work

Clinic Name:	Vista Community Clinic (VCC: The Gary Center)
Primary Contact Name and Title:	Josh Trujillo Clinical Program Manager
Primary Contact Email and Phone Number:	jtrujillo@vcc.org 562-264-6000 x6531

PHVBC Year 4: July 1, 2025 – June 30, 2026

SMART Objective	Activities	Success Metrics
1. By June 30, 2026, VCC: The Gary Center will reach 2,200 patients served by our social determinants of health (SDOH) initiative, and over 100 patients will be served by our wellness advocacy initiative, which will empower these patients to improve their chronic and preventative health outcomes.	☐ Review and update SDOH community resource list with a minimum of 3 new community social resources. ☐ Continue to recruit diabetic and hypertensive patients in poor control for our Wellness Advocate program, and expand recruitment and outreach efforts to patients who are in the risking risk category (BP >130/80 and A1c >8) ☐ Successfully enroll over 100 patients annually in the Wellness Advocacy (WA) Program. ☐ Successfully reach over 30 successful graduates in the WA program by the end of the calendar year, as measured by our WA tracking database. ☐ Administer and complete 1,100 SDOH questionnaires by the end of the calendar year.	☐ Wellness Advocacy Program enrollment and graduation totals, tracked quarterly (using WA tracking database) ☐ i2i population health tool to track completed SDOH screenings
2. By June 30, 2026, VCC: The Gary Center will have reached UDS targets for *HBA1c, Blood Pressure, and Cervical Cancer Screening* as reported by our internal data reporting: • Improving HbA1c in poor control (>9) from 27% (106/395) to 24% • Increasing BP in control (<140/90) from 69% (375/546) to 72%, and	☐ Develop a dashboard to track all project-specific measure scorecard reports across various health networks and compare them to our internal measure rates to identify and resolve any discrepancies between them. Review missing credits with health networks and formulate a workflow to ensure accurate data capturing of claims. ☐ Continue to engage Wellness Advocacy program participants to empower them to better manage their chronic conditions	☐ HbA1c >9 for diabetic patients, tracked quarterly (all eligible patients and WA Program participants) ☐ BP in control (<140/90) for hypertensive patients, tracked quarterly (all eligible patients and WA Program participants)

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• Increasing cervical cancer screening rates from 70% to 74%	☐ Our Patient Engagement team will conduct outreach for all patients due for our UDS measures through telephone calls and text messaging.	☐ Cervical cancer screening rate, tracked quarterly (all eligible patients) ☐ Internal tracking log to record patient engagement efforts.

Line-Item Budget

Clinic Name: VCC

Proposal Title: 2025-2026 Population Health and Transition to Value Based Care

Proposal Expenses	Budget Year 4	Carry Over	Year 4
Personnel			**Remaining Balance**
Program Manager	71,400	-	71,400
Referral Coordinattor	47,590	-	47,590
Wellness Care Advocate	50,357	-	50,357
Project Lead	20,947	-	20,947
TGC Clinic Manager	4,820	-	4,820
PT Eng Scheduler	43,680	-	43,680
PT Eng Scheduler	20,000	-	20,000
Subtotal	**258,794**	-	258,794
			-
Benefits (25%)	**44,765**	-	44,765
Total Personnel	**303,559**	-	303,559
Non-Personnel		-	-
Office Supplies	3,000		3,000
Local Travel	2,000	-	2,000
Copy & Printing	1,000	-	1,000
Educational Materials	2,500	-	2,500
Transportation- Uber	40,000		
Incentives	11,479		
Staff Training	2,000		
Meeting Supplies	1,000		
Population Health	30,000		
Clinical Supplies	8,000		
Computer Supplies	14,000		
		-	-
Total Non-Personnel	**114,979**	-	114,979
Subtotal Direct Costs	**418,538**	-	418,538
Indirect Costs @ 6%	**25,112**	-	25,112
TOTAL	**443,650**	-	443,650
Other Costs		-	-
Subcontracts/Consultants		-	-
		-	-
		-	-
		-	-
		-	-
		-	-
		-	-

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Total Other Costs	**-**	**-**	**-**
		-	**-**
GRAND TOTAL	**443,650**	**-**	443,650

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Budget Justification Form-VCC

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Specific Line-Item Notes:

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- *Indirect costs may not be applied to consultant or sub-awardee expenses.*

Line Item*	Amount	Justification
Program Manager	71,400	Provides leadership and oversight for planning, implementation, and coordination of population health and value-based care initiatives, ensuring program goals are met and participating health centers are effectively supported.
Referral Coordinator	47,590	Facilitates patient referrals, tracks care transitions, and ensures timely access to services to support population health management and value-based care initiatives across participating health centers.
Wellness Care Advocate	50,357	Engages and educates patients to promote preventive care, healthy behaviors, and adherence to care plans, supporting population health and value-based care initiatives across participating health centers.
Project Lead	20,947	Provides oversight and coordination for population health and value-based care initiatives, ensuring effective implementation, monitoring, and alignment across participating health centers and staff.

Line Item*	Amount	Justification
TGC Clinic Manager	4,820	Provides operational leadership at the TGC site, overseeing staff, workflows, and resources to ensure efficient clinic operations and successful implementation of population health and value-based care initiatives.
PT Eng Scheduler	43,680	Coordinates patient appointments and engagement activities to support timely access to care and the implementation of population health and value-based care initiatives across participating health centers.
PT Eng Scheduler	20,000	Coordinates patient appointments and engagement activities to support timely access to care and the implementation of population health and value-based care initiatives across participating health centers.
Benefits (25%)	**44,765**	Covers employee health and other standard benefits.
Office Supplies	3,000	Provides necessary materials and resources for staff to manage daily operations, documentation, and program activities supporting population health and value-based care initiatives.
Local Travel	2,000	Covers transportation expenses for staff to visit participating health centers, attend meetings, and engage in community outreach to support population health and value-based care initiatives.
Copy & Printing	1,000	Supports the production of materials for patient education, staff training, and program operations to advance population health and value-based care initiatives across participating health centers.
Educational Materials	2,500	Supports the development and distribution of resources to educate patients and staff, promote health literacy, and enhance the implementation of population health and value-based care initiatives.
Transportation- Uber	40,000	Provides ride-sharing support for patients to attend appointments and access services, reducing barriers to care and supporting

Line Item*	Amount	Justification
		population health and value-based care outcomes.
Incentives	11,479	Provides rewards or recognition to encourage patient engagement, adherence to care plans, and participation in preventive and population health programs, supporting improved health outcomes and value-based care initiatives.
Staff Training	2,000	Funds professional development and educational opportunities to enhance skills, build capacity, and ensure effective implementation of population health and value-based care initiatives.
Meeting Supplies	1,000	Supports materials and resources needed for staff and stakeholder meetings, trainings, and collaborative sessions to advance population health and value-based care initiatives.
Population Health	30,000	Supports implementation of technology systems and tools to manage data, track outcomes, and enhance care coordination for population health and value-based care initiatives.
Clinical Supplies	8,000	Provides essential materials and equipment for direct patient care, supporting preventive services, treatment, and the implementation of population health and value-based care initiatives.

*add more rows, as needed.

Attachment 3. Scope of Work for Consultants

Consultant Line Item
Evaluation (Center for Community Health and Evaluation – SOW attached)
Communication (4th Street Bridge – SOW attached)
Technical Assistance (IHQC – SOW attached)
Training and Consultants customized training based on roles; subject matter experts and deep dive workshops on emerging trends like AI, CMS Payment models, UDS+ , etc. (Planned SOW attached)

CENTER FOR COMMUNITY HEALTH AND EVALUATION
cche.org

Population Health and Value Based Care Initiative
Evaluation Scope of Work – Years 04 & 05

About CCHE

The Center for Community Health and Evaluation (CCHE) designs and evaluates health-related programs and initiatives throughout the United States. Our mission is to improve the health of communities with collaborative approaches to planning, assessment, and evaluation. Our team's background spans a variety of fields, including public health, economics, public policy, epidemiology, and health administration. With broad expertise in evaluation methods and experience in a wide range of health issues, CCHE combines rigor with practicality. CCHE has been the evaluation partner for the Population Health and Value Based Care (PHVBC) Initiative since its launch in 2022.

Initiative Overview

PHVBC is a $50 million, 5-year initiative to strengthen Orange County's network of community health centers. It is led by the Coalition of Orange County Community Health Centers (Coalition) with funding from CalOptima Health. The initiative aims to enhance access to care, improve quality outcomes, and strengthen the infrastructure of the health care safety net system to transition to value-based care environments. This will prepare and position Orange County health centers to more effectively serve their communities given changes and priorities in the California health care policy environment.

The initiative engages 27 safety net health centers in building capabilities related to data and quality improvement, care delivery, and access and operations. Grantees receive implementation support and complete grant requirements as part of program participation. The initiative is supported by technical assistance and coaching from the Institute for High Quality Care (IHQC) and evaluated by the Center for Community Health and Evaluation (CCHE). PHVBC is guided by a strategic framework that articulates key capabilities for successful population health management and value-based care, including several cross-cutting themes required for work in each domain. The framework was collaboratively developed in early 2023 by IHQC and CCHE with feedback from the Coalition. The Framework guides program curriculum, technical service delivery, and evaluation.

PHVBC launched in July 2022. Activities during the first year focused on health centers' understanding current state, prioritizing needs and potential strategies, and planning implementation. Years 02 and 03 focused on developing foundational capabilities and implementing small-scale quality improvement pilot projects. Years 04 and 05 will focus more intensively on closing care gaps for each health center's populations of focus and

expanding technical assistance to focus on financial and operational measures as well as clinical quality.

Evaluation Overview

The evaluation aims to understand changes in health centers' practices and capabilities, impact of implementation strategies, facilitators and barriers, and how the initiative contributed to progress.

The questions guiding the evaluation are:

1. To what extent have PHVBC organizations **strengthened capabilities** for population health management and value-based care including:
    - Improving their **quality improvement and data infrastructure?**
    - Advancing their **care delivery** practices and processes?
    - Improving their **access and operations** practices and processes?
    - Strengthening **cross-cutting key influencers** of progress (e.g., leadership, workforce and workflows, patient engagement)?
2. To what extent have PHVBC organizations improved **clinical quality measures**?
3. What has been the **impact of health center projects** on health center access/operations, care delivery, quality metrics, patient experience, and/or staff/provider experience?
4. To what extent and how has the **Coalition improved internal capacity** for supporting participating health centers (e.g., quality infrastructure, data integration, and data-driven decision making)?
5. To what extent and how has the support and funding provided by PHVBC **contributed to participants' changes in capacity and project impacts**?
6. What has been learned about what it takes to advance population health management and transformation to value-based care, including **facilitators and barriers**?

The evaluation in Years 04 & 05 will continue to focus on these questions and build on what we have learned in the first three years of the initiative.

Evaluation Scope of Work

In Years 01-03, data was collected through a health center capability assessment, quarterly progress and clinical data reports, and annual participant interviews and surveys. The evaluation also leveraged program documents including workplans and annual posters where health centers presented their PHVBC progress and impact. CCHE will continue to work closely with the Coalition and IHQC to leverage program documents and understand any adaptations in the initiative that impact the evaluation. As noted above, the evaluation

will continue to focus on the evaluation questions set at the beginning of the initiative in order to assess and document health centers' progress over time.

The following data collection activities will continue in the final two years of the initiative. The quarters listed below are the quarters of the program year (July – June), not the calendar year.

Data collection methods	Description	Year 04 (Jul 2025 – Jun 2026)				Year 05 (Jul 2026 – Jun 2027)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Capability self-assessment	Capability assessment, aligned with the strategic framework, for clinics to self-assess current capabilities. Administered at baseline, midpoint, and final.							X	
Initiative-level clinical data reporting	Teams submit clinical quality data annually on a select number of clinical metrics for their organizations using an Excel reporting template (this is in addition to data submitted quarterly on their project as part of the Project Status Report, see below).	X				X			Jul 2027
Team interviews	Annual virtual interviews with 2-4 members of each PHVBC health center team to assess progress, impact, and participant experience.			X	X			X	X
Participant survey	Annual PHVBC participant survey to collect information on progress, facilitators, barriers, and satisfaction.				X				X
Project Status Report review	Review of health centers' quarterly progress report and data dashboard to capture key accomplishments, project progress, and facilitators and barriers.	X	X	X	X	X	X	X	X
Health center poster review	Document review to capture health centers' self-reported accomplishments, challenges, and impact.				X				X
In-person convening observation	Attending in-person convenings to understand content and capture health center updates and stories of impact.		X		X		X		X

Post-event surveys *Convenings are marked by Xs. Other learning series surveys will be done as needed*	Implemented for in-person convenings and program learning series, as appropriate: a brief survey to assess usefulness and satisfaction and collect recommendations for future events.		X		X		X		X

Existing evaluation activities will be revisited to ensure continued alignment with initiative priorities and the technical assistance strategy. We anticipate that we will refresh the approach to clinical data reporting and quarterly reporting (i.e., Project Status Reports, which include data on outcome and intervention measures). More specifically:

- Cross-cutting clinical quality measures will be identified, with a goal of maintaining as much consistency as possible with initiative data collected to date
    - Measures will align with MCAS and CalOptima priorities where possible
    - Measure definitions will be defined across the program (i.e., measurement year or calendar year) and will reflect the clinic's entire Orange County population (not just patients of specific sites or providers)
- The inclusion of financial and operational measures will be explored to align with increased TA focus on these areas.

These decisions will impact the cadence and structure of clinical data reporting and what is included in the quarterly Project Status Reports.

The evaluation SOW is being expanded in Years 04 and 05 to include:

- **Evaluation of Tier 1 organizations** – At least three health centers have been identified as needing more foundational support to begin their population health work. CCHE will modify existing evaluation tools to understand their journeys and how the initiative has contributed to their readiness to engage in this work.
- **Observation of peer groups and other TA offerings** – The initiative will be relying on more focused peer groups to deliver content and facilitate peer learning. As appropriate, CCHE will observe these groups to understand content and capture examples of progress and impact being shared in these venues.
- **Capture contribution and impact of mini-grants** – Additional initiative resources will be made available to clinics through mini-grants to support their population health efforts. The evaluation will capture the overall costs of these investments & their contribution to progress.
- **Case studies/site visits to up to 3 health centers in Year 05** – In the final year, CCHE will work with the Coalition and IHQC to identify three health centers to feature as case studies. This will entail site visits to these organizations and in-depth interviews with a variety of staff and providers at the clinics to tell a story of impact and capture lessons learned.

- Participation in **PHVBC Advisory Council** – IHQC is proposing creating an advisory council with representatives from the Coalition, CalOptima, and participating health centers. CCHE will participate in and support the facilitation and materials for these meetings, including bringing evaluation data and updates to the advisory council for discussion.
- **Quarterly reporting to CalOptima** – CCHE will partner with IHQC and the Coalition to produce brief, quarterly updates of health center progress utilizing evaluation and program data.

Specific timing for these expanded evaluation activities will align with the technical assistance plan and reporting requirements.

Deliverables

The evaluation deliverables include:

- Quarterly synthesis of clinic progress for the Advisory Council and CalOptima (in collaboration with IHQC)
- Annual summative evaluation report in Sept/Oct each year
- Quarterly progress reports to the Coalition on evaluation activities

Budget Summary and Justification Years 4 -5

Budget category	Budget amount
Personnel (salaries & benefits)	$526,656
Travel	$16,232
Other Expenses	$23,150
Direct costs	**$566,038**
Indirect Costs (6%)	$33,962
Total costs	**$600,000**

Personnel

- **Maggie Jones, Site PI/ Co-Investigator** (Years 4 -5: 0.10 FTE). Maggie is the Director of CCHE and brings 25 years of experience in public health and evaluation. Maggie has been leading large-scale, multi-site evaluations of safety net improvement initiatives and learning collaboratives for the past 15 years, the majority of which have been in California. In addition to leading evaluations, she has coached safety net organizations on developing operational definitions for key measures and how to use their data to drive improvement. Maggie will play a leadership role on the project, directing project activities at all stages and managing relationships and collaboration with key partners.
- **Lisa Schafer, Co-Investigator** (Year 4: 0.28 FTE; Year 5: 0.25 FTE). Lisa is a project lead at CCHE bringing over 15 years of evaluation and learning experience. She has

led projects ranging from evaluations of health system transformation and quality improvement programs to large scale, multi-sector collaborations for health equity and systems change. She has evaluated programs designed to build capacity and support innovation in the clinical safety net, including trauma-informed care and adverse childhood experiences. Lisa has experience in qualitative and quantitative methods, evaluation technical assistance and training, and clinical data reporting coaching. She has led the development of organizational capacity assessments to support safety net partners in identifying priorities for organizational strategy, practice changes, and QI projects. Lisa will have a leadership role on the project, overseeing and supporting data collection and analysis efforts.

- **Carly Levitz, Project Manager and Data Analyst** (Year 4: 0.35 FTE; Year 5: 0.30 FTE). Carly has been with CCHE for 10 years working on projects that support improvements in health care systems in the safety net. Carly has a background in quantitative analysis and special interest in using data visualization to communicate results in ways that engage stakeholders. Her research interests include reducing disparities in quality of care and health outcomes. Carly has significant experience supporting clinical data collection (including developing data definitions), conducting data analysis, developing dashboards, and partnering with clinic or consortia teams to interpret and understand the data to inform decision making. Carly will serve as the project manager as well as having a data analyst role.
- **To Be Named Eval & Learning Associate**. (Year 4: 0.80 FTE; Year 5: 0.77 FTE) CCHE will leverage additional team members to support data collection, analysis, and reporting. These team members will have experience working with similar types of evaluations and experience working with safety net health centers.

NOTE: Personnel costs are calculated using the federally negotiated fringe rate of 38.1%. Salaries are increased in subsequent years at no greater than 3% per year.

TRAVEL

We have budgeted for trips to Orange County to meet with key partners, attend relevant meetings and convenings, conduct site visits, and present/share results.

Destination:	Orange County, CA		
Travel Expense	Unit cost		Total cost
Airfare	$350	Round-trip from Seattle	$ 350
Hotel	$300	per night for 1 night	$ 300
Meals	$120	per day for 2 days	$ 240
Ground Transportation	$250	per trip	$ 250
Total Cost Per Trip			$ 1,140

Year 4: $6,840 (6 trips); Year 5: $9,392 (8 trips)

Note: Estimates for travel for Year 4 are based on current costs and are increased in subsequent years according to KPWHRI policy.

FOURTH STREET
Bridge Strategies

SCOPE OF WORK

To: The Coalition of Orange County Community Health Centers
From: Octavio Gonzalez
Date: September 30, 2025
Re CalOptima Health Population Health Initiative

This memo summarizes the draft Scope of Work and estimated costs for the CalOptima Health Population Health Initiative run by the Coalition of Orange County Community Health Centers.

The Affordable Care Act began a shift away from fee-for service healthcare to Value-Based Care (VBC), which aims to improve overall population health and individual patient outcomes while controlling costs by focusing on prevention, coordinating care, using data to drive decisions, and rewarding quality over quantity of care. In an effort to document key learnings where VBC has improved population health, the Center for Community Health and Evaluation collected clinical data and participant feedback on health center progress, impact, and experiences, to assess the capacity of health center capacity-building initiatives. Using a strategic framework and scoring guide on a variety of areas of assessment, challenges were identified by the 27 participating health centers, which then shared key learnings, and proposed actions or solutions, which impact care. The Coalition proposes to document these learnings and patient stories via easily digestible analysis documents or long form videos to both memorialize and share these key learnings and solutions. To accomplish this, Fourth Street Bridge Strategies proposes to work with the population health evaluation team and The Coalition to collaborative interpret and distill the evaluation findings and elevate these learnings and the patient stories in such a way that patients, decision-makers, and the funder community can understand.

TERM

12 months (July 2025 – July 2026)

BUDGET

Project management, consulting ($5,000/mo., 12 months)**..... $60,000.00**

Project scoping, coordinating meetings
Evaluation team coordination and analysis interpretation drafting
Population health concept development
Travel, location scouting, logistics planning, permitting (if required)

Population Health Podcast (1 season, 10 episodes)**..... $80,000.00**

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(Pre-production, concept dev., script writing, show notes $2,000/ep..... $20,000.00)
(On-site production, equipment, post-production: $5,500/ep., 10 ep..... $53,000.00)
(2 promo videos/episode, podcast launch..... $7,000.00)

***Population Health Stories Documentation*..... $110,000.00**

Video/Written Production (Nov. - Mar.)..... $70,000.00
Post-Production, Project Delivery (Apr. - Jun.)..... $40,000.00

GRAND TOTAL..... **$250,000.00**

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Institute for High Quality Care
PHVBC Technical Assistance Scope of Work – Year 4

September 1, 2025 through August 31, 2026

Updated proposal – September 4, 2025

Overview

As the Population Health and Transition to Value-Based Care (PHVBC) Initiative moves into year 4, the participating clinic teams will transition from foundational testing/piloting efforts to deepening and scaling up their population health work. The participating clinic teams will be expected to select 2 populations of focus as defined by the Initiative, standardize workflows, add financial and operational considerations, and scale up their interventions countywide.

The PHVBC Initiative has identified 2 subgroups of participating teams (referred to as Tier 1 and Tier 2) based on assessment of progress, care delivery parameters, organizational capacity and other factors. IHQC PHVBC Technical Assistance services will be provided to each Tier to advance the participating teams' capabilities and defined goals.

Technical Assistance Scope of Work

1. **Tier 1 Specific Supports –** By June 30th, 2026, IHQC will support and coach the Tier 1 teams through a) the design and implementation of their PHVBC Tier 1 project work plans, b) the development of an organizational QI Plan, and c) documenting and assessing workflows core to their PHVBC Tier 1 projects.

2. **Learning Community Programs[1] –** By June 30, 2026, IHQC will support and coach the PHVBC participating clinics through the design and implementation of their self-defined project work plans. The supports will include the following:
    a. Semi-Annual Convenings[2] - By June 30th, 2026, IHQC will host and facilitate two semi-annual convenings for all PHVBC teams. The convening will consist of break-out sessions, plenary speakers, facilitated discussions around project updates and best practice exchange, and dedicated team time for project planning. Session evaluations will demonstrate "satisfaction" and/or equivalent ranking on the content and applicability to their ongoing PHVBC efforts.
    b. Workshops and/or Webinars - By June 30th, 2026, IHQC will host and facilitate at least two workshops and at least 2 webinars for PHVBC teams to help advance their project efforts.

[1] Learning Community Program elements are tailored predominantly for Tier 2 participating teams. However, Tier 1 and Tier 2 are expected to engage in Semi-Annual Convenings. All other opportunities are available to Tier 1 depending on their capacity to engage.

[2] Both Tier 1 and 2 teams are expected to engage in Semi-Annual Convenings.

Workshops are defined as half-day in-person sessions led by subject matter experts to provide space to participants to learn and apply skills. Webinars are defined as 60-minute web-based programs for presentation of content and/or peer-to-peer engagement. Topics will be defined based on themes across the teams' workplans and current needs identified.

c. Topic-Specific Intensives - By June 30th, 2026, IHQC will provide at least 2 topic-specific coaching/resource opportunities for PHVBC teams. Over a 3–6-month period, each of these offerings will provide teams/participants with the opportunity to dive deeper into key structural capabilities (i.e., documenting workflows and standardizing work, understanding the operational and financial drivers of value-based care, and/or designing data dashboards and engaging staff in data-driven improvement).
d. Facilitated Peer Groups - By June 30, 2026, IHQC will host and facilitate three role-specific Peer Groups – Quality, Care Teams, and Leadership. Each will meet at their self-defined cadence (e.g., bi-monthly to quarterly), and will offer forums for PHVBC team representatives to share best practices, troubleshoot common challenges, and discuss trends impacting their work.
e. QI Capacity Building - By August 31, 2026, IHQC will offer at least two QI training series to help build staff skills in quality and process improvement, implementation science, and/or project management.

3. **Finance and Operational Metrics/Considerations** – By August 1, 2026, the PHVBC Initiative will incorporate an increased focus on financial and operational considerations in Value-Based Care. IHQC will engage subject matter experts to provide trainings and generate reports – both clinic-specific and county-wide – on a standard set of financial and operational measures. Clinic-specific reports will be distributed to the clinic organization directly to maintain confidentiality. An aggregated county-wide report will be provided to the Coalition and the PHVBC participants more broadly.

4. **Coalition Capacity Building** - By August 31, 2026, IHQC will increase the capacity of the Coalition of Orange County Community Health Center (COCCHC) defined staff to design, implement and manage an improvement and/or population health initiative. Capacity will be measured by self-reported knowledge of, understanding in and application of project management tools, implementation science, facilitation techniques and QI fundamentals. IHQC will provide a) at least 2 training intensives on topics tailored for COCCHC staff, b) provide shadowing and feedback opportunities and c) support the development of actionable worksheets and tools.

5. **PHVBC Advisory Council** – By February 1, 2026, IHQC will support COCCHC in launching a PHVBC Advisory Council to include representatives from COCCHC, participating clinic teams and CalOptima. The PHVBC Advisory Council will be a forum for review and discussion on initiative-wide issues and opportunities to advance PHVBC objectives. The Advisory Council define the meeting cadence and specific agenda(s).

OTHER EXPENSES

Individual incentives: $25 incentives for up to 100 health center team members for their completion of an annual survey. Year 4:$2,500 (100 incentives); Year 5: $2,500 (100 incentives). Total Costs: $5,000.

Transcription costs: The complete transcription of each annual team interview is budgeted at a rate of $140 per interview. Transcription is needed to ensure accurate records of interviews and enable in-depth qualitative analysis. Year 4: $4,200 (30 transcriptions); Year 5: $4,200 (30 transcriptions). Total project transcription estimates: $8,400.

Site visits (Yr 05 only):

- Clinic Incentives: $2,500 incentives to up to 3 clinics for participating as case study sites, which will include in-person site visits and additional interviews. Total Costs: $7,500.
- Lunch: During the site visit days, we will be providing lunch for up to 25 clinic staff members participating in each visit. We have budgeted $30 per person for lunch. This brings the total cost to $750 for each visit. For a total of three site visits, total cost will be $2,250.

Indirect Costs

Facilities and administrative costs have been budgeted at CHCF's allowable rate of 6% of modified total direct costs.

Scope of Work: Customized Training and Consulting for Population Health and Value-Based Care

Purpose: To build the Coalition's capacity to effectively implement population health strategies, operationalize Value-Based Care (VBC) payment methodologies, and sustain the gains of the initiative **across member health centers.**

Activities

- Engage expert consultants to provide role-specific training for staff and leadership across clinical, operational, finance, and data/analytics teams. Areas such as equity centered data use, practice transformation, risk adjustment, bundled payments, and other alternative payment models,
- Develop tailored learning modules, workshops, and supporting materials reflecting current initiatives and staff roles.

Deliverables

- Role-specific training plans, materials, and reference guides
- Workshops, webinars, and/or on-site training sessions

Outcome

Staff and leadership are equipped to translate VBC payment models into actionable strategies, optimize population health management, and continue sustaining the initiative's gains, driving equitable, value-focused care across member health centers

Attachment 4. Additional Information Requested by the Grant Management Ad Hoc Committee of the Board

The following pages are the response from the Coalition per the following request:

1. Please provide further detail or Scopes of Work for the PHVBC and/or other subcontracted training/consultants included in the budgets of the following clinics. Specifically, what this training is for and how it supports each clinics individual Scope of Work:
    - Alta Med
    - Camino Health Center
    - Central City Community Health Center
    - CHOC
    - CIBD
    - Celebrating Lige Community Health Center
    - Families Together of Orange County
    - Family Health Matters
    - Friends of Family Health Center
    - KCS
    - Laguna Beach
    - Lestonnac Free Clinic
    - Livingstone Community Health Center
    - Nhan Hoa
    - Obria Medical Clinics of Southern California
    - Planned Parenthood
    - Radiant
    - Share Ourselves
    - Serve the People Community Health Center
    - Sierra Health Center
    - Southland Integrated Services
    - St. Jude Neighborhood Health Center
    - St. Youstina
    - UCI
2. How will the outcomes of the training being provided at the 24 clinics listed above be measured?
3. Will each of the 24 clinics listed above secure independent consultants, or will there be one consultant hired to provide the training for all the above clinics?
4. Please provide a more detailed description or Scope of Work for the $400,000 consultant(s) included in the Coalition's budget. Specifically, what the consultant(s) will do and how the proposed work supports the Coalition's Scope of Work.
5. Please provide additional clarity regarding how the consultant training provided in the 24 clinics above is different than the consultant training being provided by the Coalition.

Responses to CalOptima Health Questions

Population Health and Transition to Value Based Care Initiative

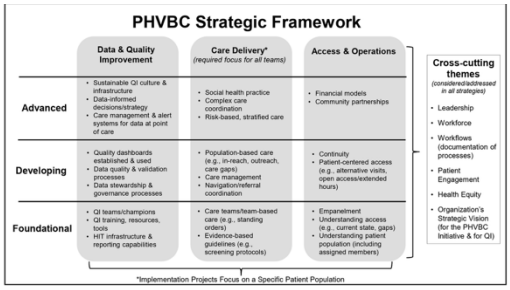
1. Please provide further detail or Scopes of Work for the PHVBC and/or other subcontracted training/consultants included in the budgets of the following clinics. Specifically, what this training is for and how it supports each clinics individual Scope of Work:

   Thank you for the opportunity to provide additional detail regarding the subcontracted training and/or consulting costs included in the participating health centers' budgets. We recognize that the Population Health and Transition to Value Based Care (PHVBC) Initiative includes both initiative-level technical assistance and clinic-specific supports. While we didn't have the opportunity to meet with the newest CalOptima Health grant management team to walk through the initiative and its design, as we requested, we are happy to clarify the distinction and purpose of the requested budget items.

   Prior to doing so, we want to ensure we provide some background on the Initiative for missing context due to lack of a formal onboarding meeting with the new CalOptima Health grant management team.

   Background
   The Population Health and Transition to Value-Based Care (PHVBC) initiative is a $50 million, five-year initiative launched in July 2022 to strengthen and prepare Orange County's community health centers for value-based care. Led by the Coalition of Orange County Community Health Centers and funded by CalOptima Health, PHVBC supports 27 safety net primary care organizations with funding, training, technical assistance, and peer learning to improve access, quality outcomes, and capabilities for population health management.

   As a reminder, below is the five-year initiative's Strategic Framework.



Definitions for the above framework include:

	Terms	Definition
Areas of Focus	Data & Quality Improvement	Activities and processes focused on building a culture of quality improvement and improving data capabilities (e.g. collection and interpretation of data, monitoring

	Terms	Definition
		data for day-to-day improvement efforts and progress on longer term organizational priorities.
	Care Delivery	Clinical care models, systems, and service lines structured around meeting the clinical care needs of patients and the communities being served.
	Access and Coverage	Activities that enable a health center to understand the demand for care from their patients, as well as services and supports to efficiently organize care delivery and operations to meet and financially sustain those services.
Stages of Capabilities	Foundational	Activities that increase organizational or staff skills or understanding of a given area of focus and can be built or created to transform clinical practice and operations.
	Developing	The coordination ofmultiple foundational skills to implement more sophisticated activities in a given area of focus or implement activities that engage a broader group of staff.
	Advanced	The integration of skills and activities from a given area of focus into an organization's overarching clinical and business operations. Skills and activities from the area of focus become fundamental to how staff at all levels approach their work.
Cross Cutting Themes	Leadership	At every stage, Senior Leadership engages in and champions population health, value-based care delivery, and improvement and implementation efforts. Leadership establishes and communicates the vision of the PHVBC project efforts and their linkages to the organization's overall strategic vision/plan.
	Workforce	Care team and staff members at every level are engaged, trained and empowered to refine and improve care delivery and operations to optimize supports for population health and value-based care.
	Workflows	Applicable workflow processes are examined and refined as necessary. Optimized workflows are documented and staff are trained.
	Patient Engagement	A patient-centered and engaged view is considered and implemented throughout each Area of Focus and Stage of Capability
	Health Equity	Health Equity and the provision of care – clinically and operationally – are considered throughout each Area of Focus and Stage of Capability to include population and risk-level stratification and care management that is equitable to the specific needs of populations being served.

	Terms	Definition
	Strategic Vision	Defining and articulating the specific Strategic Vision for the clinic organization as it relates to population health care delivery, QI and the overall organizational priorities.

Distinction Between Initiative-Level Support and Clinic-Specific Training/Consulting

Initiative-Level Consultants – Institute of High Quality Care (IHQC) (for all 27 participating health centers)

The PHVBC initiative has an overarching consulting team that provides capacity building support across all participating sites (as outlined in their SOW) through an applied learning model focused on a) knowledge building – in person, virtual, and on-demand trainings on topics designed by team needs; b) peer-to-peer learning opportunities – group activities, convenings, dialogue and exchange such as the Quality, Leadership, and Care Coordination peer groups which were launched through this initiative; and c)Coaching and Support – subject matter expertise deployed for individualized coaching and group expertise across similar themes or requests.

Leveraging the initiative's vision and strategic priorities, the initiative level consultants (IHQC) uses their experience and their applied learning model to focus on increasing the capacity of Orange County Community Clinics to implement, refine, embed, and sustain value-based care environments.

To date the initiative level consultants have conducted:

- learning collaboratives
- Peer Groups (Quality, Leadership, and Care Coordination)
- Semi-Annual Convenings
- 1:1 coaching on population health and value-based care capabilities
- Technical assistance on project design, data use, workflow improvement and change management.

These supports are designed to strengthen system-wide capacity and ensure consistency in core competencies across all clinics.

Clinic-Specific Training and Consultants (requested in individual budgets):
In addition to shared technical assistance, each health center has unique operational needs, infrastructure gaps, and population-specific priorities. Clinic-specific training and consulting allow sites to address:

- Specialized clinical or operational needs not covered by initiative level TA
- Patient Centered Medical Home certification and/or recertification.
- Local workflow redesign, population-specific interventions, clinical documentation, transitions of care, health information technology optimization (EHR, Popln Health platforms), billing and coding, etc.
- Staff development needs that differ significantly from clinic to clinic

These supports enable each clinic to successfully execute its scope of work for Year 4 and achieve measurable improvements in its chosen population of focus.

Vendors are not identified yet – and this is intentional. For participating health centers, the specific training vendors or consultants have not yet been selected. This is because, the Year 4 workplan hasn't been approved by Caloptima Health, competitive procurement or internal approval processes may be required, health centers need flexibility to engage the right resource at the right time. Therefore, the line items are included to ensure clinics have the budget flexibility to secure appropriate support as needs arise.

Initiative-level TA builds overall capacity across health centers, helps build strategy over five years in partnership with coalition, and then design specific technical assistance across 27 participating health centers and also lean into individual coaching

While the initiative provides robust shared TA—including learning collaboratives, convenings, and 1:1 coaching—the needs of each clinic vary significantly based on: I want to add something here about this isn't just year four, the whole goal is capacity. – with additional dollars to draw down it allows to expand on the budget criteria.

- Population health maturity
- EHR systems
- Staffing configuration
- Size and scale of their project
- Operational complexity across multiple sites

Clinic-specific resources give each health center the ability to dive deeper into areas that are **unique to their environment**, **tailored to their populations**, and essential for **successful scaling in Year 4**.

- Initiative-level consultants support broad capacity building for all 27 clinics.

Clinic-specific costs support *local implementation, scaling, and sustainability*, which vary by site. Below you will find specific additional information on the justification of these line items for each of the health centers listed below.

- **Alta Med**
    - Training- Supports training necessary for AltaMed staff across clinical, operational, quality an patient experience roles to implement a comprehensive cervical and breast cancer population health strategy. While the initiative provides a broad guidance on population health and value-based care, AltMed requires additional, tailored training to operationalize these approaches within its environment. Proposed training would focus on quality data interpretation and analytics to engage all staff in proactive gap closure; coding, documentation, and value based billing; revenue cycle alignment to ensure preventive services are captured, billed, and reimbursed appropriately; patient engagement and experience training including culturally and linguistically appropriate communication. These are proposed types of training to help the

organization leverage financial, quality, and patient experience data to proactively care for their population of patients, reduce disparities in screening (focus of their year four project), and meet valued based performance expectations.
    - **Consultants:** Supports engagement of specialized consultants to help AltaMed with workflows, data systems, and population management operations necessary to improve cervical and breast cancer screening rates (focus of year four project). Proposed areas for consultants include support in strengthen data integration across EHR, billing, imaging, and health plan sources to improve attribution, completeness of screening; improve coding and documentation accuracy, enhancements in revenue cycle processes. These consulting services enable AltaMed to translate initiative-level strategies into operational practice.

- **Camino Health Center**
    - **Training:** Supports staff training to standardize QI practices and strengthen Camino's population health capabilities. This includes building skills in QI methods, using standardized dashboards, interpreting crosswalked quality measures, implementing team-based care and PCMH workflows, and developing care plans for hypertensive and CRC populations. Trainings enhance staff capability—not just capacity—to scale improvements across departments and sites and align with value-based care expectations.
    -
- **Central City Community Health Center**
    - Training: Strengthens Central City staff's ability to apply initiative strategies within their unique workflows and patient populations. While initiative-level technical assistance provides overarching guidance, this local training reinforces concepts, builds staff competency, and ensures sustainable implementation of value-based care practices. Training focuses on improving diabetes outcomes through EHR alerts, workflow integration for same-day retinal screenings, and targeted patient outreach to increase A1c testing and retinal exam completion. It also enhances operational skills to reduce no-show rates and improve access to Spanish-speaking providers via optimized scheduling, additional bilingual staff, and call center support. With recent turnover and shifts in federal and state policies earlier this year, this training is especially important in supporting staff as they rebuild and strengthen quality infrastructure. By enhancing staff capability—not just capacity—this training directly supports Central City's SMART goals while maximizing the impact of centralized technical assistance
- **CHOC**
    - **Outpatient Training (QI, SQ, PM, Data):** Supports staff participation in external trainings on quality improvement, safety and quality, project management, and data analytics. These trainings enhance staff skills and strengthen implementation of population health and value-based care initiatives. By building both capability and capacity, these trainings enable CHOC staff to adapt to evolving projects each year and apply best practices to meet clinic-specific goals, such as improving PHQ-A/9 screening rates and follow-up care

for patients who screen positive, and increasing CIS Combo 10 immunization rates.
    - **Value Based Consultant:** This proposed engagement would provide specialized, targeted guidance that complements initiative-level consulting. While specific activities are not yet finalized, the consultant is intended to enhance staff capability in areas requiring expertise beyond standard technical assistance. Support may include applying advanced data analytics, quality improvement methods, or operational strategies, piloting new approaches for clinic-specific challenges, and reinforcing staff skills in niche areas. This consultant would build specialized capacity, ensuring CHOC clinics can implement and sustain value-based care and population health practices.
- **CIBD**
    - **Training:** This proposed engagement would provide specialized, targeted guidance beyond standard initiative-level technical assistance, addressing the unique needs of CIBD's specialty care setting. While specific activities are not yet finalized, the consultant is intended to enhance staff capability and clinic infrastructure in areas such as advanced workflow optimization, patient outreach strategies, data-driven quality improvement, and coordination with on-site pharmacy services. Support may include piloting interventions to improve annual visit adherence, reduce no-show rates, streamline check-out workflows, and strengthen patient adherence processes. By providing expertise beyond initiative-level technical assistance, this proposed consultant would help CIBD build sustainable capacity to implement and scale population health and value-based care strategies in a specialty care context.

- **Celebrating Life Community Health Center**
    - **Training:** Supports advanced training to strengthen Celebrating Life clinical, operational, and population health capabilities. These trainings focus on standardizing chronic disease management workflows, building staff and provider expertise in diabetes and hypertension best practices, using data to guide care, and enhancing patient engagement in self-management goal setting. By further deepening staff capability to implement these practices, the trainings directly support Celebrating Life's goal of reducing HBA1c control and increasing the percentage of hypertensive patients with blood pressure in control (year four project focus).

- **Families Together of Orange County**
    - **Training and Skill Building -** Supports hands-on, clinic-specific training to enhance staff skills and knowledge in applying population health and value-based care strategies within FTOC's workflows. Training builds both foundational skills — such as running daily patient reports, managing care huddles, and tracking follow-ups for Year 4 initiatives like cervical cancer and depression screening — and advanced application through PBVBC-focused modules on population health management, data workflows, and value-based care practices. By reinforcing initiative-level guidance with operational and project-specific skill development, this training ensures staff can translate strategies into sustainable improvements in clinic performance, patient care, and outcomes. cervical cancer and depression screening. PBVBC training

complements initiative-level technical assistance by reinforcing staff capability to implement evidence-based interventions and scale improvements across the clinic.

- **Consultants:** Represents engagement of external experts to provide specialized guidance and strategic support beyond standard initiative-level technical assistance. While specific activities are not yet finalized, the proposed consultant is intended to support clinic-specific challenges, optimize workflows, enhance care coordination, EHR optimalization, coding, and billing and pilot interventions tailored to FTOC's patient population and specialty care context. This support builds specialized staff capability, complements PBVBC and other trainings, and ensures sustainable implementation of population health and value-based care strategies, including cervical cancer and depression screening initiatives and preparation for the transition to eClinicalWorks.

- **Family Health Matters**
  - **Training:** Supports hands-on, clinic-specific training to enhance staff skills, knowledge, and capacity to implement population health and value-based care strategies. Training includes both project-focused skill-building — such as running daily patient reports, managing care workflows, and tracking interventions for diabetic patients and colorectal cancer screening — and advanced PBVBC-focused modules on population health management, data-driven decision-making, and value-based care practices. This training is distinct from initiative-level technical assistance and coaching, providing staff with the operational, role-specific, and project-level skills needed to implement FHM's Year 4 priorities. These include expanding clinic services (dental, behavioral health, mobile health, onsite pharmacy), improving HIT workflows and reporting for actionable data, increasing patient access through active panel management and expanded hours, and strengthening the clinic's presence on social media to engage the community. By reinforcing initiative-level guidance with practical, clinic-level application, this training builds sustainable staff capability, supports improved clinic performance, and enhances patient outcomes.

- **Friends of Family Health Center**
  - **Training :** Supports clinic-specific, hands-on training designed to build staff capacity and expertise in population health management and value-based care**,** complementing initiative-level technical assistance and project-specific sessions. Training focuses on developing practical, operational, and project-level skills including:
    - Optimizing workflows and patient flow to improve care delivery.
    - Using EHR data and health IT tools to identify care gaps, track interventions, and implement risk-stratified panel management.
    - Conducting patient outreach and engagement, including motivational interviewing, education, and culturally competent communication.
    - Applying clinical best practices for targeted populations, specifically diabetic patients and cervical cancer screening.

        - Implementing and evaluating interventions using tools such as driver diagrams, root-cause analysis, and workflow assessments.
        - Strengthening team-based care and communication through daily huddles and interdisciplinary coordination.

- **KCS**
    - **Training:** Supports comprehensive, clinic-specific training designed to enhance staff capacity and effectiveness in implementing population health and value-based care initiatives. This training combines foundational skill-building — including workflow optimization, patient outreach, and care gap monitoring — with advanced PBVBC-focused modules on population health management, data-driven decision-making, and value-based care practices. Staff development may include attending external trainings offered by organizations such as IHI, bringing in specialized trainers, or piloting targeted interventions, providing hands-on, role-specific, and project-focused learning opportunities. This clinic-level training goes beyond initiative-level technical assistance by allowing customized, site-specific support tailored to KCS's workflows, team structures, and patient population. It reinforces ongoing staff and care team development over the five-year initiative, supporting Year 4 goals such as improving breast cancer screening and depression screening and follow-up, while also advancing long-term clinic capacity, population health management, and value-based care practices to achieve sustainable improvements in clinic performance and patient outcomes.

- **Laguna Beach**
    - **Training:** Supports comprehensive, clinic-specific training to build staff capacity in population health management, quality improvement, and value-based care, going beyond standard initiative-level technical assistance. Training develops organization-wide competencies, enabling staff across all departments to integrate QI/QA processes, data-driven decision-making, and population health practices into routine workflows rather than relying solely on a single Quality Manager. This may include external workshops, bringing in specialized trainers, or internal skill-building to improve EMR use for risk stratification, empanelment, and proactive patient management**.** These activities strengthen the clinic's ability to manage behavioral health services, expand quality infrastructure, and embed a value-focused approach into daily operations**,** ensuring sustainable improvements in clinic performance, patient care, and population health outcomes.

- **Lestonnac Free Clinic**
    - **Training:** Supports specialized, clinic-specific training designed to build knowledge, skills, and capacity for implementing a value-based care delivery system in a free clinic setting. Training focuses on operationalizing population health strategies, optimizing workflows, and using data to monitor and improve key outcomes, including hypertension and diabetes management, appointment

adherence, and telehealth utilization. Staff gain hands-on skills in leveraging the new EHR system**,** coordinating care across medical, dental, vision, and behavioral health services, and implementing preventive care initiatives such as expanded women's health services, free surgeries, and skin cancer screening. By building organization-wide competencies, this training goes beyond standard initiative-level technical assistance, enabling staff to translate value-based care principles into sustainable improvements in clinic performance, patient care, and population health outcomes, while addressing the unique needs of uninsured and low-income patients in Orange County. Training may include external workshops, bringing in specialized trainers, or internal skill-building sessions tailored to clinic workflows and patient populations.

- **Livingstone Community Health Center**
    - **Training** Supports clinic-specific training designed to build staff knowledge, skills, and capacity in population health management and value-based care, strengthening both individual and organizational capability across core pillars including data use, workforce development, quality improvement, and empanelment. Training focuses on practical application, enabling staff to monitor clinical preventive measures, optimize workflows, and manage patient panels effectively to improve outcomes for populations such as patients due for colorectal cancer screening and preventive visits (e.g., AWVs). By providing hands-on skill-building and tailored guidance beyond standard initiative-level technical assistance, this training equips staff to implement value-based care practices sustainably, enhance clinic performance, and deliver high-quality, patient-centered care while supporting the clinic's broader strategic priorities, including workforce development, financial stewardship, and community services. Training may include participation in external workshops, bringing in specialized trainers, or internal skill-building sessions tailored to the clinic's unique workflows and patient population.

- **Nhan Hoa**
    - **Training:** Supports specialized, clinic-specific training designed to build staff knowledge, skills, and organizational capacity for effective implementation of population health and value-based care initiatives. Training will focus on clinical skill development (diabetes, hypertension, cervical cancer screening, behavioral health, and OB/GYN care), population health management (risk stratification, empanelment, and SDOH-informed patient navigation), and workflow and quality improvement (standardization of documentation, cross-departmental collaboration, and process optimization). Staff will also enhance their technology and data capabilities, including leveraging the EHR for preventive care tracking, care coordination, telehealth, and reporting for value-based care metrics. Additionally, training addresses organizational

capacity and workforce development, including leadership skills, succession planning, team-based care, and cross-training to ensure flexibility and sustainability. Staff will gain practical tools for patient engagement and community outreach, such as health literacy–informed communication, technology-enabled outreach, and strategies to improve access for underserved populations. Training may include external workshops, specialized trainers, or internal skill-building sessions tailored to NHAN's workflows and patient population. By providing hands-on, tailored training beyond initiative-level technical assistance, Nhan Hoa staff are better equipped to implement value-based care practices, optimize clinic operations, and deliver high-quality, coordinated, and patient-centered care, resulting in sustainable improvements in clinic performance and population health outcomes.

- **Obria Medical Clinics of Southern California**
    - **Training:** Supports specialized, clinic-specific training to build staff knowledge, skills, and organizational capacity for effective implementation of population health and value-based care initiatives. Training focuses on rebuilding and strengthening the clinic's quality infrastructure, enabling staff to implement the core pillars of value-based care, including data-driven decision-making, workflow standardization, patient engagement, and clinical guideline adherence. Staff will receive hands-on guidance in optimizing EHR documentation and medical record reconciliation, standardizing pre-visit and care team workflows, and implementing evidence-based cancer screening protocols for breast and cervical cancer. Training also emphasizes patient engagement strategies, such as reminders, education, and incentive programs, as well as workflow processes to reduce no-show rates and improve lab completion. By providing tailored skill-building beyond initiative-level technical assistance, this training equips Obria staff to translate value-based care principles into sustainable improvements, enhance clinic performance, and achieve measurable outcomes in preventive care, patient adherence, and population health management. Training may include external workshops, specialized trainers, or internal hands-on sessions customized to Obria's site-specific needs and patient population.

- **Planned Parenthood**
    - **Consultant:** Supports engagement of an external expert to provide specialized guidance and technical assistance tailored to Planned Parenthood's clinic workflows and organizational priorities. The consultant is expected to help staff implement population health and value-based care strategies, strengthen quality improvement initiatives,

and build staff capacity across the organization. Anticipated support may include leveraging the EMR upgrade (eCW v12) and enhanced information technology infrastructure, optimizing data workflows, and supporting adherence to 2026 PPFA medical standards and guidelines. Staff could also receive guidance on chronic disease management and preventive care processes, with particular focus on diabetic patients and cervical cancer screening. By providing hands-on, tailored expertise beyond standard initiative-level technical assistance, this support is designed to build sustainable staff competencies, strengthen clinic performance, and enhance organizational readiness for population health management and value-based care outcomes.

- **Radiant**
    - **Training:** Supports a two-tiered approach to staff development and capacity building. The Staff Training and Support line focuses on ongoing, operational-level coaching and resources to reinforce workflows, documentation, and patient engagement practices, ensuring staff can effectively implement population health and value-based care initiatives, including depression and cervical cancer screening follow-up. The PHVBC Training line provides more structured, intensive, and strategic skill-building opportunities, such as workshops, external trainings, or specialized consultants, to advance staff expertise in quality improvement, data analytics, cancer screening optimization, and comprehensive population health program implementation. Together, these complementary investments strengthen staff capability at both the operational and strategic levels, supporting Radiant's transformation from a specialty and social service provider to a comprehensive primary and specialty care organization, enhancing performance, and improving patient outcomes across clinics and community services.

- **Share Ourselves**
    - **Training:** Supports professional development and targeted educational opportunities to build staff knowledge, skills, and capacity for effective implementation of population health and value-based care initiatives. Training focuses on enhancing workflows, clinical practices, and patient engagement strategies specific to child and adolescent well visits, ensuring consistent, high-quality care delivery. By providing clinic-specific coaching and skill-building beyond standard initiative-level support, this investment strengthens staff competency, improves preventive care outcomes, and supports the sustainable application of population health and value-based care strategies within the clinic.

- **Serve the People Community Health Center**

- **Training:** Supports staff participation in intensive, organization-level population health and value-based care training designed to build skills, enhance care delivery, and strengthen clinic capacity beyond standard initiative-level technical assistance. Training is focused on advancing chronic disease management from improvement to sustained outcomes, including A1c and blood pressure control, enhancing care coordination and management from coordination to full integration, translating preventive quality measures from measurement to action, and strengthening social determinants of health interventions and community linkages. Staff will gain practical, actionable knowledge to optimize workflows, implement data-driven interventions, and improve patient engagement for diabetic patients and colorectal cancer screening. This specialized training helps establish sustainable processes and organizational capabilities that directly support the clinic's population health and value-based care objectives.

- **Sierra Health Center**
  - **Training:** Supports staff participation in population health and value-based care training to enhance knowledge, skills, and capacity for effective implementation at the clinic level. Training may include external workshops, on-site sessions, or expert-led coaching, providing specialized support beyond standard initiative-level technical assistance. Staff development will focus on embedding evidence-based practices, culturally responsive and equity-driven care delivery, optimizing primary and specialty care workflows, leveraging technology and data systems, and strengthening processes for preventive care, including cervical and colorectal cancer screening. This targeted training ensures that Sierra's staff are equipped to implement sustainable population health strategies, improve patient outcomes, and build long-term organizational capacity.

- **Southland Integrated Services**
  - **Training:** Supports staff development and educational opportunities to enhance skills, strengthen capacity, and ensure effective implementation of population health and value-based care initiatives at the organizational level. Training may include external workshops, on-site sessions, or specialized expert-led coaching, providing support beyond standard initiative-level technical assistance. Staff will gain practical skills in optimizing Electronic Health Record (EHR) workflows, improving clinical efficiency, strengthening care coordination, risk stratification, population management, and chronic disease management for diabetic patients. Additional focus includes enhancing patient engagement and education around preventive screenings and embedding systematic processes to support integrated care delivery. This specialized training builds

sustainable organizational capacity, improves quality of care, and strengthens outcomes for Southland's patient population.

- **St. Jude Neighborhood Health Center**
    - **Training:** Supports staff participation in population health and value-based care training to build knowledge, enhance skills, and strengthen capacity for effective implementation at the clinic and organizational levels. Training may include on-site workshops, external sessions, or specialized coaching, providing targeted support beyond standard initiative-level technical assistance. Staff development will focus on improving access to care, implementing standardized workflows and core competencies for care teams to work at the top of their license, optimizing quality and operational processes (including EHR, patient check-in, Paylocity, and documentation templates), and strengthening data integrity and health equity assessment. This training equips staff to apply population health strategies effectively, enhance care coordination, and improve outcomes for diabetic patients and colorectal cancer screening, while building sustainable organizational capacity.

- **St. Youstina**
    - **Consultants:** Supports engagement of external experts to provide specialized guidance and technical assistance beyond standard initiative-level support, helping the clinic strengthen capacity in population health management and value-based care. Planned consultant support may focus on expanding behavioral health services, enhancing dental and nutrition programs, integrating specialty care providers, and optimizing health IT and reporting systems through eClinicalWorks and UDS trainings. Staff and leadership would receive targeted coaching to implement sustainable workflows, improve chronic disease management—including diabetes and blood pressure control—reduce patient no-show rates, and strengthen follow-up for chronic care patients. This specialized consulting is intended to enable St. Youstina to advance clinic-wide quality improvement, optimize care delivery, and build long-term organizational capacity beyond what is provided through initiative-level technical assistance.

- UCI
    - **Training:** Supports staff participation in advanced population health and value-based care training beyond standard initiative-specific sessions to build deeper expertise, enhance skills, and strengthen capacity across the organization. Training may include external workshops, on-site sessions, or expert-led coaching, providing specialized support to help staff implement and sustain initiatives in chronic disease management, preventive care, behavioral health integration, and innovative service

delivery. Staff development will focus on improving breast cancer screening, depression screening and follow-up, expanding the scope of services, and applying data-driven approaches to enhance quality, patient engagement, and satisfaction. This training is intended to build sustainable organizational capability, ensuring that UCI staff can effectively translate knowledge into improved patient outcomes and clinic-wide performance.

2. How will the outcomes of the training being provided at the 24 clinics listed above be measured?
   The Coalition includes a third party evaluator in the planning and implementation of the initiative that collects, measures and analyzes the data gathered. As each clinic is working on their own projects, the evaluator collects data related to process, measures and outcomes based upon each clinic's specific projects. Quarterly progress reports from each clinic are provided with the reports provided to CalOptima Health indicate where each clinic's progress has been made in relation to their individual scopes of work. These reports include a combination of process measures, clinical measures and outcomes specific to each clinic and their work.

3. Will each of the 24 clinics listed above secure independent consultants, or will there be one consultant hired to provide the training for all the above clinics?

   a. The PHVBC initiative has an overarching consulting team that provides capacity-building support across all participating sites (as outlined in their SOW) through an applied learning model focused on: a) Knowledge Building: In-person, virtual, and on-demand trainings on topics tailored to team needs. b) Peer-to-Peer Learning: Group activities, convenings, and structured dialogue, such as the Quality, Leadership, and Care Coordination peer groups, launched through this initiative. c) Coaching and Support: Deployment of subject matter expertise for individualized coaching as well as group-level guidance on recurring themes or specific requests. Leveraging the initiative's vision and strategic priorities, the initiative-level consultants (IHQC) focus on building the overall capacity of Orange County Community Clinics to implement, refine, embed, and sustain value-based care models. They serve as strategic partners, providing expertise and applied learning frameworks to ensure consistency in core competencies across all clinics. These supports are designed to strengthen system-wide capacity, help build strategy over five years in partnership with the Coalition, and guide the design of clinic-specific technical assistance, including individualized coaching. Importantly, the initiative also builds coalition-level capacity**,** ensuring that by the end of five years, the Coalition possesses the skills and capability to provide advanced coaching, technical assistance, and training independently—supporting long-term sustainability of value-based care initiatives across member health centers. Regarding the 24 clinics listed above: Each clinic secure additional, specialized consultants to meet their unique needs. These consultants will be independent, providing targeted support specific to each clinic's priorities. Initiative-level consultants provide overarching guidance, capacity-building frameworks, and applied learning approaches across all clinics, while the independent consultants focus on clinic-specific training and support. Consultants have not yet been identified, as it would be

premature to secure them prior to the approval of the Year Four workplan and budget by CalOptima Health.

4. Please provide a more detailed description or Scope of Work for the $400,000 consultant(s) included in the Coalition's budget. Specifically, what the consultant(s) will do and how the proposed work supports the Coalition's Scope of Work. Given our Year 4 workplan and budget has not been approved yet, we have not sought out the consultants to assist with the scope we provided initially (see below).

Scope of Work: Customized Training and Consulting for Population Health and Value-Based Care

Purpose: To build the Coalition's capacity to effectively implement population health strategies, operationalize Value-Based Care (VBC) payment methodologies, and **sustain the gains of the initiative across member health centers.**

Activities

- Engage expert consultants to provide **role-specific training** for staff and leadership across clinical, operational, finance, and data/analytics teams. Areas such as equity centered data use, practice transformation, risk adjustment, bundled payments, and other alternative payment models,
- Develop tailored learning modules, workshops, and support materials reflecting current initiatives and staff roles.

Deliverables

- Role-specific training plans, materials, and reference guides
- Workshops, webinars, and/or on-site training sessions

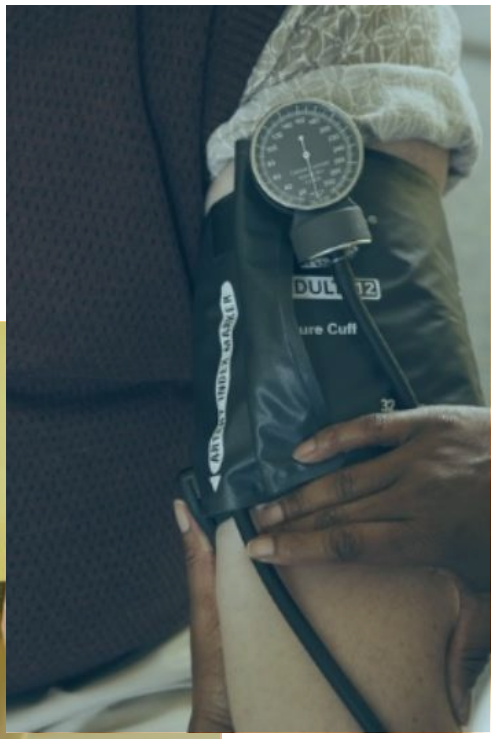
Outcome

Staff and leadership are equipped to **translate VBC payment models into actionable strategies, optimize population health management, and continue sustaining the initiative's gains**, driving equitable, value-focused care across member health centers

October 2025

Population Health and Value-Based Care Initiative

Interim Evaluation Report Executive Summary – Year 3



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Executive Summary

PHVBC background

The Population Health and Transition to Value-Based Care (PHVBC) initiative is a $50 million, five-year initiative launched in July 2022 to strengthen and prepare Orange County's community health centers for value-based care. Led by the Coalition of Orange County Community Health Centers and funded by CalOptima Health, PHVBC supports 27 safety net primary care organizations with funding, training, technical assistance, and peer learning to improve access, quality outcomes, and capabilities for population health management. The evaluation aimed to understand changes in clinics' capabilities and practices, impact of implementation strategies, facilitators and barriers, and how PHVBC contributed to progress.

Evaluation findings

Progress in **Year 3 built on accomplishments made during the first two years of PHVBC.**

Year 1	Year 2	Year 3
Baseline assessments showed that PHVBC teams were generally early in their journeys related to population health management (PHM) and value-based care (VBC).	Teams established stronger infrastructure to support PHM and VBC work. This included hiring data and quality improvement (QI) staff, improving data systems, establishing care team practices, implementing care management strategies, and building PHM workflows.	Teams strengthened capabilities across all domains of PHM—data and QI, care delivery, and access and operations. Additionally, teams started to see improvements in process and outcome measures related to pilot projects.

This report focuses on the results from Year 3, which are organized into five key findings:

1. PHVBC health centers continued to strengthen quality improvement (QI) and data infrastructure and workflows.

Baseline assessments found most teams lacked robust QI and data systems resulting in relatively low capabilities. In Year 3, **most participants (92%) indicated they had strengthened capabilities related to data and QI because of PHVBC's support.** Midpoint assessments showed notable improvements in the QI and health information technology (HIT) domains, with average scores rising from approximately 2.5 to over 3.0 (on a 1–5 scale, with 5 indicating the strongest capacity).

PHVBC teams initially focused on strengthening QI and data infrastructure including hiring specialized staff, forming QI committees, and developing policies and procedures. In Year 3, **health centers began leveraging their strengthened data systems to inform PHM work, and emphasis shifted to improving data quality, optimizing health information technology (HIT), and supporting broader data utilization.**

Despite progress, teams reported ongoing challenges such as limited HIT functionality, manual data processes, and difficulties accessing health plan data. Organizational challenges—like staffing constraints, turnover, and leadership support—also influenced progress.

2. Teams improved care delivery capabilities, especially establishing systems for more effective population-based care and social health practice.

Teams started the initiative with variability in their care delivery capabilities. In Year 3, **94% of participants reported that PHVBC strengthened their care delivery capabilities.** Additionally, midpoint assessments showed improvements across all care delivery domains, with larger growth in areas rated lower at baseline (i.e., population-based care and social health practice).

- PHVBC health centers increased implementation of **consistent, multidisciplinary care teams**. They improved communication and collaboration through strategies like provider-Medical Assistant dyads and co-located pods.
- PHVBC projects resulted in more **proactive population-based care practices**, including workflow standardization, improved in-reach (pre-visit planning, huddles) and outreach.
- Health centers **enhanced care coordination** through dedicated staff, focused referral coordination, and patient-centered workflows.
- Almost all teams have started **implementing social health screening**, including developing workflows, training staff, and building community partnerships to address housing, food, and transportation needs.

3. Health centers are beginning to report improved performance on clinical quality measures.

At the end of Year 3, **many health centers were beginning to show improvements in both their project measures and the annual initiative measures.** More health centers were also meeting benchmarks than at the beginning of the program.

Did at least half of health centers with project measures related to these health topics improve at least one project measure during year 3?

Diabetes	Hypertension	Breast cancer	Colorectal cancer	Cervical cancer
☑	☑	☑	☑	☑
11 of 14 HCs	3 of 6 HCs	6 of 8 HCs	8 of 9 HCs	8 of 11 HCs

For the initiative-wide measures collected for the health centers' full populations, did...

Rate of:	...the overall cohort average improved for this measure?	...at least half of those reporting this measure improve over time? **	...more health centers' performance meet or exceed external benchmarks in 2023 compared to 2025? ***
Hemoglobin A1c >9%*	☑ +5.8%	☑ 7 of 9 HCs	☑ +10 HCs
Controlling high blood pressure	☑ +2.7%	☑ 5 of 7 HCs	☑ +7 HCs
Breast cancer screening	☑ +2.4%	☑ 4 of 6 HCs	☑ +7 HCs
Colorectal cancer screening	☑ +0.2%	☑ 4 of 6 HCs	☑ +1 HCs
Cervical cancer screening	⊗ -5.1%	⊗ 2 of 5 HCs	☑ +2 HCs

*Hemoglobin A1c is an inverse measure where lower values are better; the 5.8% is a decrease, which is an improvement.
**Denominator is the number of health centers who had data in both 2023 Q2 and 2025 Q2.
***The benchmark for colorectal cancer screening is from CMS High Quality Rating System MPL Measurement Year 2023. The benchmark for the other four measures is the DHCS Minimum Performance Level from Measurement Year 2023.

4. Teams had fewer efforts dedicated explicitly to access and operations; they reported some improvements in related capabilities, which overall continued to be variable.

Teams started PHVBC with variable capabilities related to access and operations with about half of teams reporting low capabilities. Teams initially cited insufficient data infrastructure to provide them with the information needed to advance access and operations. In Year 3, teams discussed some focus on access and operations where it was aligned with care delivery strategies—**79% of participants indicated that PHVBC strengthened their access and operations capabilities.** The financial models domain had the largest gains while the other two domains had more modest improvements.

- **Financial models:** PHVBC helped health centers better understand the link between PHM and VBC and helped leaders begin to make the case for investing in efforts to advance VBC in their organizations. Ongoing support is needed to prompt culture change and shifting mindsets from a fee-for-service orientation to value-based care.
- **Community partnerships:** This was a priority for about half of PHVBC teams, especially those implementing social health screening. Efforts included creating community resource lists, culturally responsive patient education and outreach, and organizing preventive care events.
- **Empanelment, continuity, and access:** PHVBC teams were in early stages of this work and discussed challenges. More significant progress on empanelment was associated with involvement in other non-PHVBC transformation programs.

5. PHVBC effectively supported teams in advancing primary care capabilities and improving clinical measures, but challenges remain.

The resources and structure provided by PHVBC contributed to increased capabilities and infrastructure to support QI, data analytics, and population-based care delivery, which improved performance in clinical measures. **94% of participants were satisfied with PHVBC's contribution to their progress**, elevating:

- **Grant funding** that allowed them to hire staff and dedicate time to PHVBC.
- **Structure and accountability** that kept teams on track and moving the work forward.
- **Sense of direction** by helping teams see the connection between foundational capabilities for PHM and the vision for value-based care.
- **Focus on data and QI**, which increased health center infrastructure that they were able to leverage to support care delivery and access/operations priorities.
- **Prioritization of patient experience**, including seeking input and feedback directly from patients.

PHVBC participants reported high engagement and positive experiences with the initiative overall, indicating that the grant funding and semi-annual in-person convenings were the aspects of the initiative that contributed most to their progress. The most significant benefit of the in-person events were the opportunities for peer learning and connection.

While PHVBC has contributed to teams' significant progress, teams also continued to report challenges that influenced their PHVBC work. The challenges that were most frequently discussed included:

- **Workforce and staffing instability** including turnover and burnout at all levels
- **Leadership engagement and support** for PHM and VBC work, including the need for leaders to reinforce the vision, dedicate resources, and manage change
- **Data and data infrastructure**, including ongoing issues with accessing timely, accurate, and actionable data, including access to external data from health plans and community partners
- **Patient engagement** in their care to close care gaps
- Uncertainty about the **external environment** (e.g., federal funding, the future of Medicaid)

Summary

In its first three years, PHVBC has advanced population health management (PHM) and the shift toward value-based care (VBC) by enhancing team capabilities and fostering organizational change. Participating teams improved quality and data infrastructure and piloted care delivery projects focused on strategies like in-reach, outreach, care coordination, and social health screening. These efforts contributed to improved clinical outcomes related to diabetes, hypertension, and cancer screening. Teams continued to face challenges with access, empanelment, funding, and workforce. Going into Year 4, teams emphasized the need for ongoing assistance to scale their pilot projects to broaden impact.

Considerations

Based on learnings from the first three years of PHVBC, the following considerations are offered:

FOR HEALTH CENTERS

- Quality data is the foundation of transformational work
- Leadership buy-in and communication is essential
- Work requires a team approach and dedicated time
- Start small and approach the work with a learning mindset

FOR THE PHVBC INITIATIVE

- Build on foundational capabilities to support spread and scale
- Develop a tiered approach to engage health centers with different levels of experience and capacity
- Deepen focus on access and operations strategic framework area for interested health centers
- Monitor how changes in the external environment are affecting participating health centers
- Support health centers navigating challenges in the Orange County health care environment

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FOR CALOPTIMA HEALTH

Areas for potential engagement with PHVBC included:

- Navigating limited and building broader specialist networks
- Improving referral systems and authorizations
- Increasing timely access to CalOptima Health data on their health center to support health centers' QI and empanelment efforts (e.g., performance on key clinical quality measures, patient assignment lists)
- Troubleshooting issues around reimbursement and credentialing

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 4, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

15. Approve Actions Related to the Orange County Community Health Assessment and Community Health Improvement Plan

Contacts

Michaell Rose, DrPH, LCSW, Chief Health Equity Officer, (657) 235-6757
Marie Jeannis, RN, MSN, CCM, Executive Director, Equity and Community Health, (714) 246-8591

Recommended Actions

1. Authorize the Chief Executive Officer or designee to execute and administer a one-year grant agreement with the Orange County Health Care Agency and award payment of up to $990,678.46 to support the implementation of the Orange County Community Health Assessment and Community Health Improvement Plan.
2. Approve allocation from unallocated Intergovernmental Transfer 8-10 funds in an amount not to exceed $990,678.46 to fund the one-year grant agreement.
3. Make a finding that such expenditures are for public purposes and in furtherance of CalOptima Health's mission and purpose.

Background

In 2023, the Department of Health Care Services (DHCS) launched the CalAIM Population Health Management (PHM) Program as a statewide initiative designed to ensure all Medi-Cal members have access to a comprehensive set of services based on their needs and preferences.

The DHCS CalAIM PHM Program removed the requirement for managed care plans (MCPs) to submit an annual Population Needs Assessment to DHCS. Instead, MCPs are now required to:

- Collaborate with Local Health Jurisdictions (LHJs) on the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP), including the LHJ CHA/CHIP timeline alignment; and
- Meaningfully participate with their LHJ in the development and implementation of the CHA/CHIP.

In Orange County, the LHJ is the Orange County Health Care Agency (OCHCA).

The CHA is a comprehensive analysis that identifies key needs and issues by engaging the community through surveys, focus groups, and the collection and review of existing and new countywide data. CalOptima Health, OCHCA, and external stakeholders collaborated to publish Orange County's CHA in October 2023.

The CHIP is the implementation plan based on CHA findings and was released in April 2024. The 2024 – 2027 Orange County CHIP identified six priority areas and workgroups that focused on mental health, substance use, diabetes and obesity, housing and homelessness, care navigation, and economic disparities.

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The CHA/CHIP cycle is a continuous and ongoing process that assesses the community's health, implements targeted initiatives, evaluates the effectiveness of these initiatives, and measures outcomes. The Orange County CHIP implementation period will run from 2024 to 2027. In 2028, as mandated by DHCS, CalOptima Health and OCHCA will align CHA/CHIP process timelines and begin a new three-year cycle with a CHA.

DHCS's goal is for MCPs to collaborate with local health departments, community-based organizations, and other stakeholders to better understand the needs and assets of the communities served and reduce siloed efforts to improve member health outcomes.

In the CalAIM PHM Policy Guide released July 2025, DHCS defines meaningful participation by MCPs as collaboration with LHJs and the provision of funding and/or in-kind staffing:

Collaboration	Funding and/or In-Kind Staffing from MCP to LHJ	
	Funding	In-Kind Staffing
• Attending key CHA/CHIP meetings • Serving on the CHA/CHIP governance structure and subcommittees	• Administrative support (staffing resources) • Project management • Consultant support for CHA/CHIP • Communications • Data infrastructure • Community engagement • Implementation strategies specific to CHIP	• Project management • Data analysis • Stakeholder engagement activities

Since 2023, CalOptima Health leadership and staff have been meeting the DHCS collaboration requirements by participating in LHJ CHA/CHIP meetings, workgroups, and subcommittees.

MCPs are required to report meaningful participation activities to DHCS on an annual basis.

Discussion

In 2024, DHCS required MCPs to collaborate with LHJs and determine the funding and/or in-kind staffing that corresponds to the number of Medi-Cal members served in each LHJ jurisdiction.

Starting in 2025, DHCS requires MCPs to contribute funding and/or in-kind staffing resources to the LHJ to support the CHA/CHIP process. CalOptima Health and OCHCA collaborated and decided to meet the CHA/CHIP MCP contribution requirement by funding $990,678.46 through a grant award.

On August 12, 2025, the Orange County Board of Supervisors approved OCHCA's application for a $990,678.46 grant award from CalOptima Health. OCHCA submitted the formal grant request letter to CalOptima Health on September 25, 2025.

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Staff recommends that the CalOptima Health Board of Directors (Board) allocate an amount not to exceed $990,678.46 from unallocated Intergovernmental Transfer (IGT) 8-10 funds to support the one-year grant agreement with OCHCA to implement the Orange County CHA/CHIP.

Additionally, staff recommends that CalOptima Health execute a one-year grant agreement with OCHCA for funding and in-kind staff resources as required by DHCS to support the implementation of the Orange County CHA/CHIP.

With Board approval, staff would like to proceed with the prompt development and execution of the grant agreement with OCHCA. Staff will provide oversight of the grant pursuant to CalOptima Health Policy AA.1400: Grant Management and will return to the Board to provide updates on the status of the grant in future meetings.

As required by DHCS, staff will continue working with OCHCA to identify additional funding and/or in-kind staffing needed to support the full CHA/CHIP cycle. Staff will return to the Board with a formal request for any additional funding.

Fiscal Impact

A previous Board action on June 5, 2025, closed certain Board-approved IGT 8, 9, and 10 initiatives and transferred the remaining funds totaling approximately $9.0 million to an unallocated IGT 8-10 fund to deliver covered services for Medi-Cal members. The recommended action to approve the allocation of $990,678.46 from these unallocated reserves has no additional fiscal impact.

Rationale for Recommendation

CalOptima Health staff recommends proceeding with the requested actions to ensure compliance with DHCS's requirement to collaborate and contribute funding and/or in-kind staffing resources to OCHCA, supporting the successful implementation of the CHA/CHIP.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by This Recommended Board Action
2. OC HCA Board-Approved Grant Application Letter
3. Draft Grant Agreement
4. CalOptima Health Policy AA.1400 Grant Management

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Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
June 5, 2025	Authorize Actions Related to the Board Approved Initiatives Reserve Fund and Intergovernmental Transfer-Funded Initiatives	N/A	$9,886,905

/s/ Michael Hunn *11/25/2025*
Authorized Signature **Date**

Attachment to the December 4, 2025 Board of Directors Meeting – Agenda Item 15

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Orange County Health Care Agency	405 West 5th Street	Santa Ana	CA	92701

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VERONICA KELLEY, DSW, LCSW
AGENCY DIRECTOR

LORRAINE DANIEL, MPA
ASSISTANT AGENCY DIRECTOR

REGINA CHINSIO-KWONG, DO
COUNTY HEALTH OFFICER

405 W. 5TH STREET, 7TH FLOOR
SANTA ANA, CA 92701
www.ochealthinfo.com

COUNTY HEALTH OFFICER

September 25, 2025

Michael Hunn, Chief Executive Officer
CalOptima Health
505 City Parkway West
Orange, CA 92868

RE: Board-Approved Grant Application to CalOptima Health – $990,678.46

Dear Mr. Hunn,

The OC Health Care Agency has been approved by the Board of Supervisors to apply for a grant award in the amount of $990,678.46 from CalOptima Health. Please see the attached *Grant Application* approved August 12, 2025.

Upon review and approval by both OC HCA and CalOptima Health, *acceptance* of the funding is contingent on Board of Supervisors approval.

The proposed funding is in alignment with the California Department of Health Care Services' (DHCS) *Population Health Management (PHM) Program*, a cornerstone of the *California Advancing and Innovating Medi-Cal (CalAIM)* initiative. This support affirms CalOptima Health's substantial commitment to addressing the population health issues that drive the health of our Orange County communities. As outlined in DHCS All Plan Letter (APL) 23-021, Medi-Cal Managed Care Plans (MCPs) are required to contribute funding and/or in-kind staff resources to support Local Health Jurisdictions' Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs) commensurate with the number of Medi-Cal members served by each MCP within its jurisdiction.

Thank you for your continued partnership in improving the health of Orange County residents. We look forward to working together to ensure a coordinated and effective implementation of these critical CHA and CHIP efforts.

Sincerely,

Regina Chinsio-Kwong, DO
County Health Officer

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GRANT AWARD AGREEMENT

BETWEEN

CALOPTIMA HEALTH

AND

ORANGE COUNTY HEALTH CARE AGENCY

THIS GRANT AWARD AGREEMENT ("**Agreement**") is made and entered into as of January 1, 2026 ("**Effective Date**"), by and between Orange County Health Authority, a county organized health system for the County of Orange, California dba CalOptima Health ("**CalOptima**), and County of Orange, through its Health Care Agency ("**Grantee**"), a county government agency. CalOptima and Grantee may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a public agency formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

B. CalOptima's mission is to serve its members and look after their health with excellence and dignity, respecting the value and needs of each person.

C. The California Department of Health Care Services ("**DHCS**") CalAIM Population Health Management ("**PHM**") Policy Guide requires Grantee to conduct the Orange County Community Health Assessment ("**CHA**") and develop a Community Health Improvement Plan ("**CHIP**").

D. Grantee desires to coordinate the Orange County CHA/CHIP in accordance with Grantee's grant project described in Attachment A ("**Grant Project**").

E. CalOptima finds that the Grant Project is a community program that supports and is compatible with CalOptima's mission and that CalOptima desires to provide financial support for the Grant Project in the manner described in Attachment B ("**Grant Award**") and in accordance with CalOptima's policies and procedures, subject to Grantee's compliance with the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between the Parties hereto as follows:

I. GRANTEE OBLIGATIONS

1.1 **Grantee Eligibility**. Grantee hereby warrants that it is, and shall remain throughout the term of this agreement, a local public agency registered in California.

1.2 **Grantee Activities**. Grantee agrees (i) to diligently pursue the Grant Project, as specified in Attachment A, attached hereto and incorporated herein by this reference, (ii) to use the Grant Award solely for activities as identified in Attachment A, ("**Grant Activities**"), (iii) to expend funds in accordance with this Agreement and all federal, state, and local statutes and regulations, and (iv) to return any grant funds determined to have been improperly paid, in order to avoid forfeiture of the entire Grant Award. In the event of any conflict between the Grant Project in Attachment A and the rest of this Agreement, this Agreement, including all other Attachments, shall prevail.

1.3 **Unauthorized Use of Funds**. Grantee shall use Grant Funds in accordance with this Agreement, applicable laws, and the approved Grant Activities. CalOptima retains the right to recover any and all Grant Award funds if it (or any of its regulators) determines that (i) any portion of the Grant Award was not expended as provided under the terms of this Agreement, or (ii) Grantee did not comply with the Agreement or applicable federal and state laws, regulations, guidance and/or funding source requirements.

1.4 **Limitations on Subcontracting**. The experience, knowledge, capability, and reputation of Grantee, its directors and employees were a substantial inducement for CalOptima to enter into this Agreement. Grantee shall not contract with any entity to perform the Grant Project without written approval of CalOptima. Grantee shall be fully responsible to CalOptima for the acts and omissions of its subcontractor(s), if any, as it is for the acts and omissions of persons directly employed by Grantee. In the event that CalOptima approves any subcontracting, nothing contained in this Agreement shall create any contractual relationship between any subcontractor(s) and CalOptima. All persons engaged in the work under the Grant Proposal by Grantee will be considered employees of Grantee. CalOptima will deal directly with and make payment hereunder solely to Grantee.

1.5 **Subcontracts**. To the extent that subcontracting is authorized by CalOptima under this Agreement, Grantee shall assure that all subcontracts are in writing and include any requirements of this Agreement that are appropriate to the service or activity and assure that the subcontract shall not terminate legal liability of Grantee under this Agreement.

1.6 **Communications Provisions**. Grantee must comply with CalOptima's Guidelines for Endorsements and Use of CalOptima Name or Logo policy.

1.6.1 **Use of CalOptima name or logo**: Grantee shall submit requests to CalOptima's CalAIM department, in writing, at least twenty-one (21) calendar days in advance of the date for which use of the name or logo is required. Upon receipt of a complete request for use of the CalOptima name or logo, CalOptima's CalAIM department shall review and analyze the request with input from appropriate internal departments. For more information or to submit a request, email calaim@caloptima.org. The CalAIM department shall submit a request for use of the CalOptima name or logo to the Communications Department for review and consideration and will notify Grantee in writing after a determination has been made.

1.6.2 **All other uses of CalOptima's name**: Grantees may not use CalOptima's name, including in the title of Grantee's program, without prior written approval from CalOptima.

1.6.3 **Use of Grantee's name or logo:** Grantee owns all rights to the name, trademarks, logos and symbols of Grantee. The use and/or reproduction of Grantee's name, trademark, logo and/or symbol for any purpose, including commercial advertisement, promotional purposes, announcements, displays or press releases, without Grantee's express prior written consent is expressly prohibited.

II. GRANT PAYMENTS

2.1 **Grant Payments**. Payment of the Grant Award to Grantee under this Agreement will be as set forth in Attachment B, incorporated herein by this reference, which shall be payment in full for the Grant Project. Grantee acknowledges and agrees that this is a single Grant Award and that nothing herein obligates CalOptima to any further funding, whether for the Grant Project or future related or unrelated activities. The Parties acknowledge that the source of Grant Award funding is Intergovernmental Transfer Funds (IGT), and not DHCS funds, and as such the payments made hereunder are not subject to DHCS State Contract terms or federal or state claims processing requirements.

2.2 **Grant Award Use Limitations**. Grantee acknowledges and agrees that the Grant Award may not be used for achievement of milestones that have been previously paid for or will be paid for by the state or federal government or any other source. Further, Grantee acknowledges and agrees that it will not use the Grant Award to reimburse costs or liabilities it incurred prior to the date of the Grant Award.

III. WARRANTIES/COMPLIANCE WITH CALOPTIMA AND REGULATORY AGENCY RULES AND REGULATIONS

3.1 **Compliance with Applicable Laws**. In carrying out the Grant Project, Grantee shall comply with the CalOptima policies and procedures and all other applicable CalOptima policies, as made available to Grantee on CalOptima website, as well as all applicable federal, state and local laws, rules, and regulations.

3.2 **Health Insurance Portability and Accountability Act (HIPAA) Compliance**.

3.2.1 Grantee and CalOptima shall comply with all applicable federal and state laws and regulations governing the privacy and security of health information, including but not limited to the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), the Health Information Technology for Economic and Clinical Health ("**HITECH**") Act, the California Confidentiality of Medical Information Act ("**CMIA**"), and any regulations promulgated thereunder ("**HIPAA Requirements**") in performing their obligations under the Agreement. The Parties acknowledge that the purpose of the Agreement is not to exchange, disclose, or access protected health information (as defined under HIPAA) or medical information (as defined under CMIA), and Grantee attests that it shall not disclose any protected health information or medical information under the Agreement. If Grantee inadvertently receives any protected health information or medical information during the term of the Agreement, Grantee shall promptly notify CalOptima and delete the information. If the Parties decide at a later date to expand the scope of the Agreement to include protected health information or medical information, the Parties shall amend this section to reflect that purpose and execute CalOptima's form business associate agreement, which CalOptima has made available to the Grantee, prior to disclosing or accessing any protected health information or medical information under the Agreement.

3.3 **Confidentiality of Information**.

3.3.1 Grantee and its employees, agents, and subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to Grantee, its employees, agents, or subcontractors as a result of this Agreement. Grantee and its employees, agents, and subcontractors shall not use such identifying information for any purpose other than carrying out Grantee's obligations under this Agreement. Grantee and its employees, agents, and subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Grantee shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by the Member or in accordance with applicable law or court order, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, including without limitation a finger or voice print or a photograph.

3.3.2 Notwithstanding any other provision of this Agreement, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 C.F.R. Section 431.300 *et seq.*, Welfare and Institutions Code Section 14100.2, and any regulations adopted thereunder. For the purpose of this Agreement, all information, records, data, and data elements collected and maintained for the operation of the Agreement and pertaining to Members shall be protected by Grantee from unauthorized disclosure. Grantee may release Member medical records in accordance with applicable law or court order pertaining to the release of this type of information. Grantee is not required to report requests for medical records made in accordance with applicable law or court order. With respect to any identifiable information concerning a Member under this Agreement that is obtained by Grantee, its employees, agents or subcontractors, Grantee:

(a) Will not use any such information for any purpose other than carrying out the express terms of this Agreement,

(b) Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for medical records in accordance with applicable law,

(c) Will not disclose except as otherwise specifically permitted by this Agreement, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 C.F.R. Section 431.300 et seq., Welfare and Institutions Code Section 14100.2, and regulations adopted there under, and

(d) Will, at the termination of this Agreement, return all such information to CalOptima or maintain such information according to written procedures sent to the Grantee by CalOptima for this purpose.

3.4 **Conflicts of Interest**. No director, officer, employee, or Agent of Grantee may obtain a financial interest or benefit from the Grant Project, including any subcontracts, during their tenure with Grantee and for one (1) year thereafter. Grantee also represents and warrants that it does not have an existing financial or business relationship with any director, officer, or employee of CalOptima. Grantee and its members, officers, employees, agents, designees, and subcontractors will comply with all applicable laws and CalOptima policies regarding conflicts of interest, and Grantee shall incorporate, or cause to be incorporated, in all subcontracts relating to the Grant Project a provision that includes the requirements of this section. Grantee will immediately notify CalOptima of any violation of this Section 3.4.

IV. RECORDS AND REPORTS

4.1 **Maintain Complete Books and Records**. Grantee shall create and maintain such books and records relating to the Grant Activities performed under this Agreement as required by applicable laws and CalOptima policies and procedures. All financial records shall be maintained in accordance with generally accepted accounting principles ("**GAAP**"). Records generated in the course of carrying out this Agreement shall be maintained for ten (10) years from the date of the grant award, or the date of the completion of any audits related to this Agreement, whichever is later. Grantee shall provide CalOptima or its designated agents, within ten (10) calendar days of a written request, information or copies of records necessary to verify and substantiate compliance with the terms of this Agreement. Grantee shall pay all duplication and postage costs associated with any audits and/or reviews necessary to ensure compliance with this Agreement or CalOptima's regulatory requirements. This Section 4.1 shall survive the termination of this Agreement.

4.2 **Reports**. Grantee shall submit all reports as specified in Attachment C, "Grant Report Schedule," attached hereto and incorporated herein by this reference.

4.3 **Monitoring**. CalOptima shall have the right to perform Grant Program and fiscal monitoring of Grantee to ensure compliance with federal and state requirements and the terms of this Agreement, including auditing, or having audited by an independent third party, Grantee regarding the Grant Project, Grant Award, and related expenses. Grantee shall fully cooperate with CalOptima's monitoring under this section, including any CalOptima auditor. Grantee must resolve any monitoring findings to CalOptima's satisfaction by the deadlines set by CalOptima and refund to CalOptima any amounts found to have been improperly expended from the Grant Award within thirty (30) days of the notice of such improper expenditures. Grantee shall be entitled to challenge any audit finding through appealing through CalOptima's grievance process.

V. INSURANCE AND INDEMNIFICATION

5.1 **Grantee Comprehensive General Liability ("CGL")/Automobile Liability**. Grantee at its sole cost and expense shall maintain a program of self insurance including coverage for general liability and automobile liability insurance to insure it against any claim or claims for damages arising by reason of (a) personal injuries or death occasioned in connection with the carrying out the project, (b) the use of any property of the Grantee, and (c) Grant Activities performed in

connection with the Agreement, with minimum coverage of one million dollars ($1,000,000) per incident/two million dollars ($2,000,000) aggregate per year.

5.2 **Workers Compensation Insurance**. Grantee at its sole cost and expense shall maintain a self insurance program of workers compensation insurance within the limits established and required by the State of California and employer's liability insurance with minimum limits of liability of one million dollars ($1,000,000) per occurrence/one million dollars ($1,000,000) aggregate per year.

5.3 **Captive Risk Retention Group/Self Insured**. Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self-insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's and approves the waiver.

5.4 **Cancellation or Material Change**. The Grantee shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Agreement without prior notification to CalOptima.

5.5 **Certificates of Insurance**. Except to the extent waived pursuant to Section 5.4, prior to execution of this Agreement, Grantee shall provide Certificates of Insurance to CalOptima showing the required insurance coverage with respect to the performance hereunder.

5.6 **Indemnification**. Grantee shall defend, indemnify and hold harmless CalOptima and its officers, directors, and employees from and against any and all claims (including attorneys' fees and reasonable expenses for litigation or settlement) that are related to or arise out of the Grantee's negligence, willful performance or non-performance or breach of any duties or obligations of Grantee arising under this Agreement. Neither termination of this Agreement nor completion of the acts to be performed under this Agreement shall release Grantee from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.7 **Notification of Claims**. CalOptima agrees to promptly notify Grantee of any claims or demands that arise and for which indemnification or Grantee's duty to defend hereunder is sought.

5.8 **Termination.** Sections 5.7 and 5.8 shall survive the termination of this Agreement.

VI. TERM AND TERMINATION

6.1 **Term of Agreement**. This Agreement will commence on last date of execution for the Parties and will remain in effect up to and including one (1) year from effective date ("**Termination Date**"), or completion of the Grant Project, whichever occurs first. CalOptima, in its sole discretion, may extend the term of the Agreement where the Grantee has not completed the Grant Project by the Termination Date. Grantee must request such an extension in writing, setting forth good cause for the request, prior to the Termination Date. If CalOptima opts to grant the term extension, it shall set forth

the terms and conditions of the extension in writing, including the duration of the extension and reporting requirements during the extension. If Grantee does not accept those terms and conditions, the Agreement will terminate on the Termination Date.

6.2 **Termination**. If Grantee fails to fulfill any of its duties and obligations under this Agreement, including but not limited to: (i) committing acts of unlawful discrimination; (ii) engaging in prohibited marketing activities; and, (iii) committing fraud or abuse relating to any obligation, duty or responsibility under this Agreement (such as falsifying data in any reports; failing to maintain eligible status (non-profit in good standing), etc.), CalOptima may terminate this Agreement for cause pursuant to Section 6.3.

6.3 **Termination for Cause**. Notwithstanding and in addition to any other provisions of this Agreement, CalOptima may terminate this Agreement for cause effective upon thirty (30) calendar days' prior written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 6.2. Grantee may appeal CalOptima's decision to terminate the Agreement for cause by filing a complaint pursuant to CalOptima policies and procedures. Grantee shall exhaust this administrative remedy, including requesting a hearing if permitted under CalOptima policies and procedures, for any and all Grantee complaints before commencing any civil action.

CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Agreement.

6.4 **Automatic Termination**. This Agreement shall terminate automatically if the DHCS State Contract between CalOptima and DHCS is terminated.

6.5 **Bankruptcy**. CalOptima or Grantee may terminate this Agreement with thirty (30) day written notice to the other Party in the event (i) a petition is filed in a court of record jurisdiction to declare either Party bankrupt or for reorganization under the bankruptcy laws of the United States or any similar statute of a state of the United States, or (ii) if a trustee in bankruptcy or a receiver is appointed for such Party, and such petition, trustee, or receiver, as the case may be, is not dismissed within one hundred and twenty (120) days thereof.

VII. GENERAL PROVISIONS

7.1 **Interpretation of Agreement Language**. CalOptima has the right to final interpretation of the Agreement language when disputes arise. Grantee has the right to appeal disputes concerning Agreement language to CalOptima.

7.2 **Waiver**. Any failure of a Party to insist upon strict compliance with any provision of this Agreement shall not be deemed a waiver of such provision or any other provision of this Agreement. To be effective, a waiver must be in writing that is signed and dated by the Parties.

7.3 **Assignment**. Neither this Agreement nor any of the duties delegated herein shall be assigned, delegated or transferred by Grantee without the prior written consent of CalOptima. CalOptima may assign this Agreement and its rights, interests and benefits hereunder to any entity

that has at least majority control of CalOptima or to any entity whose financial solvency has been approved by Grantee, which approval shall not be unreasonably withheld. If required, any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the appropriate state and federal agencies.

7.4 **Independent Parties**. Grantee acknowledges that it is, at all times during the term of this Agreement, acting as an independent contractor under this Agreement and is not as an agent, employee, or partner of CalOptima. Grantee agrees to be solely responsible for all matters relating to compensation of its employees, including, but not limited to, compliance with laws governing workers' compensation, Social Security, withholding and payment of any and all federal, state and local personal income taxes, disability insurance, unemployment, and any other taxes for such persons, including any related employer assessment or contributions required by law, and all other regulations governing such matters, and the payment of all salary, vacation and other employee benefits. At Grantee's expense as described herein, Grantee agrees to defend, indemnify, and hold harmless CalOptima, its directors, executives, officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of Grantee's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "**Employment Claim(s)**"). Grantee shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

7.5 **Integration of Entire Agreement**. This Agreement contains all of the terms and conditions agreed upon by the Parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations, or representations of or between the Parties, either oral or written, relating to the subject matter of this Agreement that are not expressly set forth in this Agreement are null and void and of no further force or effect. All attachments to this Agreement are considered part of this Agreement and are hereby incorporated herein.

7.6 **Independent Agreement.** Nothing in this Agreement shall affect any other contractual relationships between the Parties, such as an agreement for the provision of medical services to Members. No monies paid under this Agreement may be used for the provision of services that are payable under a different contract between the Parties, or for any other purpose beyond the Grant Project as set forth in Attachment A.

7.7 **Invalidity or Unenforceability**. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other term or provision.

7.8 **Amendment**. CalOptima may amend this Agreement immediately upon written notice to Grantee in the event such amendment is required in order to maintain compliance with applicable state or federal laws; such amendments shall be limited to the minimum language necessary to comply with applicable state or federal law. Other amendments to the Agreement shall be effective only upon mutual, written agreement of the Parties.

7.9 **No Waiver of Immunity or Privilege**. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

7.10 **Choice of Law**. This Agreement shall be governed by and construed in accordance with the laws of the State of California. The Parties consent to the jurisdiction of the California Courts with venue in Orange County, California.

7.11 **Force Majeure**. Either Party shall be excused from performance hereunder for any period that a Party is prevented from meeting the terms of this Agreement as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war, but excluding labor disputes, (a "**Force Majeure Event**") provided such Party uses commercially reasonable efforts to mitigate its effects and gives prompt written notice to the other Party. The time for the performance shall be extended for the period of delay or inability to perform due to such occurrences up to a period of ten (10) days at which time the Party unaffected by the Force Majeure Event may immediately terminate this Agreement upon written notice to the other Party without liability.

7.12 **Interpretation**. Each Party has had the opportunity to have counsel of its choice examine the provisions of this Agreement, and no implication shall be drawn against any Party by virtue of the drafting of this Agreement.

7.13 **Headings**. The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

7.14 **No Liability of County of Orange**. As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Grantee hereby acknowledge and agree that the obligations of CalOptima under this Agreement are solely the obligations of CalOptima, and that the County of Orange, State of California, shall have no obligation or liability therefor.

7.15 **Non-liability of Officials and Employees of CalOptima**. No official or employee of CalOptima shall be personally liable to Grantee in the event of any default or breach by CalOptima, or for any amount that may become due to Grantee, or any obligation under the terms of this Agreement.

7.16 **Time of Essence**. Time is of the essence in the performance of this Agreement.

7.17 **Authority to Execute**. The persons executing this Agreement on behalf of the Parties warrant that they are duly authorized to execute this Agreement, and that by executing this Agreement, the Parties are formally bound.

7.18 **Counterparts**. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall be deemed one and the same instrument.

7.19 **Notices**. All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the Party to whom notice is given, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid, addressed to the party to whom notice is to be given and such Party's address as set forth below or such other address provided by notice.

To: CalOptima Health
Attention: CEO
C/O: CalAIM
505 City Parkway West
Orange, California 92868

To: Grantee
Orange County Health Care Agency
Procurement & Contract Services
405 W. 5th St. Suite 600
Santa Ana, CA 92701

7.20 **Dispute Resolution**.

7.20.1 Meet and Confer. If either Party has a dispute arising under or related to this Agreement, the Parties shall informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 7.20.2.

7.20.2 Arbitration. Subject to the California Government Claims Act (Cal. Gov. Code §900 *et seq*.) governing claims against public entities, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Agreement shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express

agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

7.20.3 Exclusive Remedy. With the exception of any dispute that under applicable laws may not be settled through arbitration, arbitration under Section 7.20.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Agreement that is not resolved through the meet-and-confer processes.

7.20.4 Waiver. By agreeing to binding arbitration as set forth in Section 7.20.2, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

7.21 **Survival**. The following provisions of this Agreement shall survive termination or expiration of this Agreement: Sections 1.3 (Unauthorized Use of Funds), 1.6 (Communications Provisions), 3.3 (Confidentiality of Information), 4.1 (Maintain Complete Books and Records), 4.3 (Monitoring), 5.7 (Indemnification), 7.1 (Interpretation of Agreement Language), 7.2 (Waiver), 7.4 (Independent Parties), 7.7 (Invalidity or Unenforceability), 7.9 (No Waiver of Immunity or Privilege), 7.10 (Choice of Law), 7.12 (Interpretation), 7.20 (Dispute Resolution), and any other Agreement provisions that by their nature are intended to survive termination or expiration of this Agreement.

7.22 **Recitals and Exhibits**. The recitals and attachments to this Agreement are made a part of the Agreement by this reference.

VIII. SIGNATURES

IN WITNESS WHEREOF, the Parties have, by their duly authorized representatives, executed this Agreement, to be effective the date first written above:

FOR GRANTEE:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
«Signatory»_____	«CalOptima_Health_Signatory»_____
PRINT NAME	PRINT NAME
«Title_of_Signatory»_____	«CalOptima_Health_Signatory_Title»
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT A
Grant Project

Grantee agrees to implement the agreed upon scope of work as described in this Attachment A.

I. Overview of the Grant Program.

This grant supports Grantee's implementation of a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP). A CHA is a comprehensive analysis that identifies key public health needs and issues through the review of local data. The CHA informs the development of the CHIP, a strategic roadmap for addressing priority health concerns identified by the community, that is implemented in the general population, including among CalOptima members.

II. OBJECTIVES

By the end of the Agreement, Grantee will facilitate implementation of the CHA/CHIP process, which serves as a shared plan to guide collective action by community members, organizations, agencies, health systems, and other local leaders, with the goal of improving health outcomes across Orange County.

This grant will support the Grantee in achieving the following objectives by the end of the grant period:

1. Within 60 days of grant agreement execution, develop a12-month Implementation Plan with timeline and objectives for the CHA/CHIP process that incorporates California Department of Public Health (CDPH) requirements. If one is already created for CDPH purposes, CalOptima will accept a copy of that plan.
2. Ensure that 100% of Implementation Plan (referenced in objective 1) milestones are executed, tracked and reported on through dedicated administrative and project management support.
3. Convene a Population Health Collaborative Steering Committee to meet quarterly (for a total of four) and the OC-CHIP Steering Committee to meet quarterly (for a total of four), per CHA/CHIP charter guidelines to guide implementation and decision-making.
4. Deploy web-based data visualization tools and conduct one training session with each of the six CHIP Implementation workgroups on data sharing and analysis.
5. Ensure community participation in four quarterly CHA/CHIP meetings by offering support such as food and bus tickets to ensure at least five community representatives attend each.
6. Publish at least two communication products (e.g., media posts, success stories, or newsletters) to promote CHA/CHIP awareness and progress.
7. Provide technical assistance (such as the MAPP tool or other technical resources) during monthly meetings with local health jurisdictions, managed

care plans, OC-CHIP Steering Committee, and CHIP Implementation workgroups.

Through this partnership, CalOptima and Grantee aim to align resources and efforts to advance health equity and improve the well-being of all who call Orange County home.

III. SCOPE OF WORK

1. GRANTEE'S ROLE/RESPONSIBILITIES

Grantee will provide collaborative opportunities to CalOptima in support of CalOptima's compliance obligations with DHCS CalAIM PHM requirements and lay the groundwork for a unified Community Health Improvement Plan (CHIP) in 2028, in alignment with DHCS PHM requirements. This work will be facilitated through the development of structures, processes, and relationships that enable a single, collaborative CHIP to be created by Grantee, Medi-Cal Managed Care Plans operating in Orange County, any electively participating non-profit hospitals or health agencies, as well as additional community partners.

Activities may include:

- Shared governance development and planning
- Stakeholder engagement
- Data collection, analysis and asset mapping
- Cross-sector collaboration and capacity building
- Community-centered planning and implementation

2. CALOPTIMA'S ROLE/RESPONSIBILITIES

CalOptima shall provide financial and technical support for the CHA/CHIP process, as well as:

a) Supporting outreach to Medi-Cal stakeholders, providers, and members;
b) Identifying and engaging internal and external partners in the CHA/CHIP Process, including, but not limited to the:
    a. Member Advisory Committee
    b. Provider Advisory Committee
    c. Population Health Committees
    d. Other governing and advisory bodies.
c) Sharing relevant CalOptima data to support the CHA;
d) Participating in shared governance and planning bodies; and
e) Supporting and participating in implementation of strategies aligned with PHM requirements and identified priorities.

3. DELIVERABLES

Grantee must lead and complete the CHA and CHIP processes, including all activities described in Section III.1. The following deliverables must be submitted to CalOptima and produced by Grantee:

a) Within 60 days of grant execution, provide the Implementation Plan as referenced above, which includes:
    a. A timeline of key activities and milestones based on objectives
    b. Designated responsible parties
    c. Initial milestones, including but not limited to:
        i. Sharing of quantitative and qualitative data on health outcomes and disparities across agencies;
    d. Establishment or adoption of a CHA/CHIP Governance Body within one month of grant execution, with meetings held at least quarterly.
b) Grant reporting required per Attachment C.

ATTACHMENT B
Grant Payment

CalOptima has made a Grant Award to Grantee in the amount of nine hundred and ninety thousand, six hundred and seventy-eight dollars and forty-six cents ($990,678.46), which shall be the maximum amount payable for the Grant Project and which shall be paid following execution of the Agreement in the time and manner set forth below.

Payments: Payments under this Agreement shall be made in two installment according to the schedule listed below. The first payment will be made upon Agreement execution. The final payment is contingent upon CalOptima's receipt and approval of the mid-year progress report and line-item budget report for the Grant Project. Such report and budget must be acceptable to CalOptima and demonstrate progress toward Grant Project. CalOptima may delay or withhold Grant Award payments at its sole discretion if such report and/or budgets are not submitted timely or as otherwise required or if CalOptima is not satisfied with any submitted reports/budgets and/or Grantee's progress on Grant Project objectives.

If Grantee's actual Grant Award expenditures are expected to vary by more than ten percent (10%) ("**Variation Threshold**") from any CalOptima-approved line-item budget entry, Grantee must obtain prior written approval from CalOptima before spending any amount of the Grant Award in excess of the Variation Threshold. Failure to obtain CalOptima's prior written approval for expenditures in excess of the Variation Threshold shall constitute a breach of the Agreement and entitle CalOptima to recoup some or all of the Grant Award, in its sole discretion.

In addition, CalOptima shall only issue the Final Payment of the Grant Award after Grantee has timely completed its Grant Project objectives to date and met all its reporting obligations under the Agreement, and spent a minimum of eighty percent (80%) of the Grant Award previously received from CalOptima under this Agreement. CalOptima may withhold or reduce Grant Award payments, in its sole discretion, if Grantee has not spent a minimum of eighty percent (80%) of the Grant Award previously received from CalOptima in accordance with the Agreement requirements, including the Grant Project description in Attachment A.

Payment Schedule:

Initial Payment of $495,339.23 upon Agreement execution.

Final Payment of $495,339.23 contingent upon submission to and approval by CalOptima of the six month grant narrative and budget report and expenditure of at least 80% of payment #1.

Return Funds: Grantee shall refund to CalOptima any funds that are found to not have been utilized in accordance with the requirements of this Agreement, including Section III of

Attachment A. CalOptima shall have the right to audit, or to have audited by an independent third party, all Grant Project expenses. Grantee shall fully cooperate with CalOptima or its auditor and shall refund to CalOptima any amounts found to have been improperly expended from the Grant Award, including where Grantee breached the Agreement, within thirty (30) days of the notice of such improper expenditures. The potential recoupment of Grant Award funds pursuant to this section is in addition to, and not in lieu of, any other rights and remedies of CalOptima under this Agreement.

ATTACHMENT C
Grant Report Schedule

Purpose of Grant Reports

In an effort to help ensure successful grant outcomes, CalOptima actively monitors and evaluates grant progress through monthly meetings with Grantee and requires that Grantee submit a final report. These reports are intended to help both CalOptima and Grantee appraise progress toward funding objectives.

Grant Report Requirements

All grant recipients must complete the Grant Report Form provided through written communication with CalOptima's Grant Management Department. Please note that successful completion of reports are a condition of grant funding and incomplete reports will delay the disbursement of future grant payments, if multiple payments are being dispersed.

The Grantee shall make every reasonable effort to complete all project activities and appropriate expenditures as defined in Attachment A by the Term Date specified in the Grant Award Agreement. The Grantee shall provide a final report to CalOptima within thirty (30) days after the program end date so that the report may be audited and approved for final payment. If the deadline cannot be met, a written explanation and the new anticipated date of completion must be provided to CalOptima. CalOptima will allow up to ninety (90) days from the Term Date for full closeout phase, which includes necessary reviews to successfully close out the grant.

Report Submission Schedule

CalOptima Health will provide the Grantee with narrative and budget reporting forms for the following reporting requirements. This grant requires the submission of two reports over the duration of the project timeframe as follows:

- **Semi-Annual Progress Report**
  - Specific due dates and Reporting Periods Covered:
    - Report #1 Due July 30, 2026 covering January 1, 2026 – June 30, 2027.

- **Final Report** will be due within thirty (30) calendar days after the end of this Grant Agreement.
  - Specific due date and Reporting Period Covered:
    - Report #2 Due January 30, 2027 covering January 1, 2026 – December 31, 2026.

CalOptima may require additional reporting from the Grantee during the term of the Agreement, as CalOptima determines in its sole discretion.

Policy:	AA.1400
Title:	**Grant Management**
Department:	Medi-Cal & CalAIM
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 08/07/2025*
Effective Date:	05/04/2023
Revised Date:	08/07/2025
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

I. PURPOSE

This policy outlines the criteria for awarding Grant funds and the expectations of Grantees for discretionary Grant funding disbursed by CalOptima Health. Quality incentive pay for value programs are excluded from this policy.

For the purpose of this policy, the key distinctions between a grant and a service contract are as follows:

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.

Service Contract: A service contract is a commercial agreement to procure specific goods or services, under which the contractor agrees to deliver the specified goods or services in exchange for a fixed fee, hourly rate, or per-deliverable price, which may include profit or markup above actual cost.

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

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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 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:

i. Has directly assisted in drafting or in preparing the specifications, requirements, or cost estimates for that Grant;

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;

iii. Is not a registered tax-exempt 501(c)3 nonprofit organization, or a governmental body, or a municipality, or a registered educational institution or tribal entity;

iv. Is not in good standing with the Secretary of State as a 501(c)3;

v. Has an active grant with a duplicative Scope of Work or budget with CalOptima Health, where being a sub-awardee does not apply; or

vi. Is not in good standing with CalOptima Health, good standing being defined by:

a) Having closed all previous grant awards as indicated by a close out letter from CalOptima Health;

b) Having no active investigations or corrective actions with CalOptima Health; and

c) Having no open investigations or legal proceedings with any federal agencies.

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.

4. CalOptima Health will review the Board of Directors composition of each grant applicant for potential conflicts of interest and advise the CalOptima Health Board of Directors accordingly;

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. When funding opportunities allow for indirect expenses in the requested budget, CalOptima Health will allow a standard indirect cost rate not to exceed fifteen percent (15%) only applicable to personnel, salary, and benefit expenses.

2. Grant Award fund disbursements may only be approved by an authorized person pursuant to CalOptima Health's Policy GA.5002: Purchasing.

3. 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.

4. 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;

   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 toward program objectives and fund expenditure 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.

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, is not expending released funds in a timely manner, or is not meeting other Grant Agreement requirements. CalOptima Health may request that the Grantee realign performance objectives if deemed appropriate.

6. The Grantee will submit an electronic copy of their annual independent audit each year within thirty (30) days of its completion.

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.

   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

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
08/07/2025	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	12/05/2024	AA.1400	Grant Management	Administrative
Revised	08/07/2025	AA.1400	Grant Management	Administrative

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 (NOFO)	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.

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 4, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

16. Authorize the Submission of the Letter of Intent to Apply to Covered California for Plan Year 2027

Contact

Donna Laverdiere, Executive Director, Strategic Development, (714) 986-6981

Recommended Action

Authorize the Chief Executive Officer to submit a Letter of Intent to Apply as an interested Qualified Health Plan applicant to Covered California for plan year 2027.

Background

On August 1, 2024, the CalOptima Health Board of Directors (Board) authorized the Chief Executive Officer (CEO) to convene a stakeholder steering committee composed of key external partners and providers to discuss considerations for potential participation in Covered California. CalOptima Health leadership and staff convened the Covered California Stakeholder Steering Committee, which has met on 14 separate occasions. On October 3, 2024, the Board directed the CEO to request the Orange County Board of Supervisors (BOS) to amend CalOptima Health's governing ordinance to remove the prohibition on participation in Covered California. On January 14, 2025, the BOS unanimously voted to amend the ordinance to allow CalOptima Health's participation in Covered California.

Since that time, CalOptima Health has made significant progress toward preparations to enter the Covered California program. On June 16, 2025, CalOptima Health submitted the initial filing to DMHC to expand the scope of CalOptima Health's current Knox Keene Act license to enable CalOptima Health to offer a Covered California product. In addition, CalOptima Health has taken several actions to expand the scope of current administrative services contracts to support operation of the Covered California line of business. Another key step in the preparations to enter the program for plan year 2027 is the submission of a non-binding Letter of Intent to Apply to Covered California.

Discussion

The Qualified Health Plan (QHP) certification is a multi-phased process that CalOptima Health must initiate by early 2026 to obtain the proper approvals to participate in Covered California beginning with plan year 2027. The process requires the submission of a non-binding Letter of Intent to Apply by February 13, 2026.

The Letter of Intent to Apply is an Excel form that all applicants for QHP certification must complete every program year. The submission is non-binding but is required to obtain access to the electronic submission portal for the QHP Application. Letters of Intent to Apply must be submitted via email by interested applicants on the required template, which includes information about CalOptima Health as an organization such as Federal ID and contact information, high-level information on proposed plan

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offerings, and the proposed service area. While the Letter of Intent to Apply has not yet been released by Covered California for plan year 2027, the template for plan year 2026 has been included as an attachment for reference.

The full timeline of the QHP Certification process is provided in the table below.

Key Actions *(Based on Draft PY 2027 QHP Application)*

Action	Date/Timeframes
Letter of Intent to Apply Due	February 13, 2026
Completed QHP Application Due	April 30, 2026
Final QHP Contingent Certification Decision	July 2026
QHP Contract Execution	September 2026
Final QHP Certification	October 2026

Fiscal Impact
There is no fiscal impact. Program costs associated with Covered California will be included in future Covered California operating budgets or separate Board actions.

Rationale for Recommendation
The recommended action will allow CalOptima Health to submit a Letter of Intent to Apply to Covered California by February 13, 2026.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Program Year 2026 Letter of Intent to Apply to Covered California

/s/ Michael Hunn *11/25/2025*
Authorized Signature **Date**

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Covered California
Letter of Intent To Apply for Plan Year 2026 Certification

The Covered California Letter of Intent (LOI) to apply is non-binding, but must be submitted by the deadline, February 14, 2025 at 5:00 pm PST to receive applicant trainings and login information to access the electronic application submission portal.

A separate LOI must be completed for each application type an Applicant intends to apply for: QHP Individual, QHP CCSB, QDP Individual, and QDP CCSB.

Covered California will provide Applicant trainings once an Applicant emails the completed LOI to QHPCertification@covered.ca.gov by February 14, 2025 at 5 pm PST. Applicant confirmation of LOI receipt and training information will be sent to the "Contact Name" listed in the "Contact Information" tab. The training information may be shared with additional applicant representatives. The trainings will assist with completing application responses, including how to access and use the electronic application submission portal.

Applicant must work with the applicable regualtor to ensure all required plan filings, including but not limited to: licensure, networks, benefit designs, and rate filings, will be submitted by all due dates to ensure timely review of all products to be offered on Covered California.

E-mail completed LOI to QHPCertification@covered.ca.gov by February 14, 2025 at 5:00 pm PST with the subject line: Qualified Health Plan Intent to Apply.

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Covered California
Letter of Intent To Apply for Plan Year 2026 Certification

E-mail completed form to QHPCertification@covered.ca.gov by February 14, 2025 at 5:00 pm PST.
Provide the following information:

NAIC Company Code	
NAIC Group Code	
Applicable Regulator(s)	
Federal Employer ID	
HIOS/Issuer ID	
Issuer Name	
Address	
City	
State	
ZIP	
Contact Name	
Contact Title	
Contact Phone Number	
Contact E-mail	
Provide an Application Point of Contact:	
Contact Name	
Contact Title	
Contact Phone Number	
Contact E-mail	

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Letter of Intent: Plan Type by Zip Code
QHP Certification Application for Plan Year 2026
Individual Marketplace

Instructions: Complete a column for each distinct product type (i.e., HMO, PPO, EPO, Other). Underneath the product type please indicate the metal tiers offered (i.e., Platinum (P), Gold (G), Silver (S), Bronze (B), Bronze HDHP (H), Catastrophic (C)). **For returning applicants, only indicate additions to last year's plan offerings or select the box below to indicate no new plan offerings.**

☐ For returning Applicants, select if there are no changes from the previous plan year.

Example:

Covered California Rating Region	***County***	***FIPS County Code***	***Zip Code***	***Zip-County Code***	***Zip Code Split Across Counties***	**HMO**	**PPO**	**EPO**	**Other**

Do not make any changes to the columns or rows.

Covered California Rating Region	*County*	*FIPS County Code*	*Zip Code*	*Zip-County Code*	*Zip Code Split Across Counties*	**HMO**	**PPO**	**EPO**	**Other**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 4, 2025
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

1. Make an exception to CalOptima Health Policy GA.5002: Purchasing and authorize the Chief Executive Officer, or designees, to execute a contract amendment without competitive procurement with Health Management Associates, Inc. for Strategic Advice and Qualified Health Plan Application support to update the payment terms from a total contract amount of $250,000 to $1.0 million.
2. Appropriate and allocate up to $350,000 from existing reserves to fund the contract amendment with Health Management Associates, Inc. for the period of July 1, 2026, through December 31, 2026.

Background

On October 3, 2024, the CalOptima Health Board of Directors (Board) authorized staff to request the Orange County Board of Supervisors (BoS) amend CalOptima Health's governing ordinance to allow participation in Covered California. On January 14, 2025, the BoS unanimously voted to amend the ordinance to allow CalOptima Health's participation in Covered California. CalOptima Health has made significant progress toward preparations to enter the Covered California program.

To assist CalOptima Health staff with the regulatory preparation for Covered California, on December 5, 2024, the CalOptima Health Board approved a contract amendment with Health Management Associates, Inc. (HMA) to provide Strategic Advice and Qualified Health Plan (QHP) Application Support in the amount of $250,000 from Fiscal Year (FY) 2025 through FY 2027, contingent upon adoption of the amended ordinance. This action made an exception to CalOptima Health GA.5002: Purchasing by allowing execution of the contract amendment without competitive procurement. The contract amendment with HMA was executed on February 6, 2025.

Discussion

Since execution of the contract, HMA has provided strategic advice and input on key deliverables that support the Covered California implementation, including input that informed the development of CalOptima Health's initial filing to the Department of Managed Health Care to expand the scope of CalOptima Health's current Knox Keene Act license. The Board approved this initial filing on June 5, 2025. HMA has been providing strategic advice across multiple program workstreams, using its prior

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Covered California implementation experience with Inland Empire Health Plan (IEHP) and LA Care to inform its support to CalOptima Health.

HMA's specialized experience will be needed moving forward as CalOptima Health staff continue to implement operational functions and processes, including information technology solutions, to support the Covered California line of business. Specifically, HMA's experience assisting health plans with the interpretation of regulatory requirements, the development of the QHP application submission, and design and development of operational functions required for the Covered California line of business will be critical in helping CalOptima Health launch the new product line.

The current contract with HMA includes the below schedule of tasks and deliverables. The table indicates the areas of the scope that require additional funds.

Topic	Purpose of Deliverable	Time Frame
Network Strategy	Strategic advice on the design of the CalOptima Health Covered CA provider network	Complete by February 28, 2025 *Completed*
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	Complete by April 30, 2025 *Completed*
Knox Keene Licensure Filing Subject Matter Expertise	Review of specific licensure filing documents as needed	Complete by December 31, 2025 *Completed*
QHP Application Support	Strategic advice and document review to support the QHP Application and negotiation process	Complete by September 30, 2026 *In Progress – Additional Resources Needed*
Support on Operational Requirements	Strategic advice on operational requirements that must be met by CalOptima Health to complete the QHP application to enroll and serve Covered California enrollees	Complete by September 30, 2026 *In Progress – Additional Resources Needed*

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The additional funds will be used for the following ongoing activities:

- QHP application
- Strategic advice for operational implementation

The current contract with HMA has a maximum allowable budget of $250,000. Staff requests an additional amount of $750,000 to support ongoing work through December 31, 2026. $400,000 in associated funding is budgeted under Non-Salary Operating Expenses within the CalOptima Health FY 2025-26 Covered California Operating Budget. An additional $350,000 will be allocated from existing reserves to fund the necessary HMA support for the period of July 1, 2026, through December 31, 2026. This will bring the total contract amount to $1.0 million. This increased contract amount will fund activities related to the contracted tasks outlined in the table above through December 31, 2026.

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 subject to exceptions set forth in the policy. Those exceptions include where CalOptima Health determines the services are additions to a critical system already procured from a vendor and/or the services have unique performance factors. Given that CalOptima Health has a contract in place with HMA for strategic advice on Covered California and QHP support, the amended contract would allow continuation of critical HMA activities leading to the launch of the Covered California product in January 2027 without potential delays or disruptions in the submission of the QHP application and implementation timelines. CalOptima Health staff request the Board authorize an exception to the Purchasing Policy due to the circumstances described above and approve amending the existing contract with HMA to expand the budget for additional support.

Contracted Support Estimated Costs	**Contract Award Amount**
Strategic Advice and Qualified Health Plan (QHP) Application Support	**$250,000**
Additional Support through the end of Calendar Year 2026	**$750,000**
TOTAL	**$1,000,000**

Fiscal Impact

The fiscal impact to update payment terms in the HMA contract to support strategic advice and QHP application support through December 31, 2026, is $750,000.

Fiscal Year 2025-26: $400,000 in associated funding under Non-Salary Operating Expenses within the CalOptima Health FY 2025-26 Covered California Operating Budget will support HMA activities through June 30, 2026.

Fiscal Year 2026-27: An appropriation of up to $350,000 from existing reserves will be included in the FY 2026-27 Covered California Operating Budget to fund HMA activities for the period of July 1, 2026, through December 31, 2026.

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Rationale for Recommendation

The recommended actions will allow CalOptima Health to continue to contract for the necessary professional services to develop a new Covered California line of business.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Current Contract Amendment between CalOptima Health and Health Management Associates, Inc.

Board Action

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 5, 2024	Approve Actions Related to Covered California Consulting Support Contracts and Associated Funding	N/A	$250,000

/s/ Michael Hunn *11/25/2025*
Authorized Signature **Date**

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AMENDMENT NO. 2 TO CONTRACT 24-10974
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE,
DBA CALOPTIMA HEALTH
("CalOptima")
AND
HEALTH MANAGEMENT ASSOCIATES, INC.
("CONTRACTOR")

AMENDMENT NO. 2 to this CONTRACT is entered into as the date last signed below ("Amendment Effective Date"), with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "Party" or collectively as "the Parties") entered into Contract 24-10947 on May 15, 2024, under which CONTRACTOR agreed to provide Growth Strategy Assessment Services as described in the Scope of Work, Exhibit A.

B. Pursuant to Section 10 of the Contract, the Contract may be amended only in writing executed by the Parties.

C. The Parties desire to extend the term of the Contract as provided herein.

D. The Parties desire to add the attached Scope of Work Exhibit A-1 to the Agreement.

E. The Parties now desire to amend Exhibit B of the Agreement to incorporate payment costs related to Exhibit A-1, Scope of Work.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. All capitalized terms used herein shall have the same meanings given them in the Agreement unless the context specifically provides otherwise herein.

2. Section 13 is amended to align with the deliverable schedule in Exhibit B-2, for work under Exhibit A-1. The Term of the Contract is extended and will continue in full force and effect through October 1, 2026 ("Term") unless earlier terminated as provided in the Contract.

3. Exhibit A- Scope of work is amended to include Exhibit A-1, attached.

4. Exhibit B. Payment Fee Schedule is amended to include the attached Exhibit B-2, for completed work under Exhibit A-1 and will not exceed $250,000. All payments made to Contractor under Exhibit B-2 will be paid upon written acceptance of the described.

5. Exhibit B, Section 4 is amended to increase the maximum cumulative payment obligation. The Contract shall not exceed $336,125.

6. **Authority to Execute.** The persons executing this Amendment on behalf of the Parties warrant that they are duly authorized to execute this Amendment and that by executing this Amendment, the Parties are formally bound.

7. **Counterparts.** This Amendment may be executed in any number of counterparts, all of which taken together shall constitute one and the same instrument, and any of the Parties hereto may execute the Amendment by signing any such counterpart.

8. **No Other Changes.** This Amendment No. 2 is by this reference made part of said Contract. Except as otherwise provided in this Amendment, all of the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Amendment and any provisions of the Contract and prior amendments, if any, the provisions of this Amendment No. 2 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Agreement. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 2 on the day and year last shown below.

HEALTH MANAGEMENT ASSOCIATES, INC.

Signature: Signed by: Jeffrey M. DeVries E36A79D3FDA045D...

Name: Jeffrey M. DeVries

Title: Contracts Senior Director

Date: January 28, 2025 | 11:34 EST

Signature: _____

Name: _____

Title: _____

Date: _____

CALOPTIMA HEALTH

Signature: Signed by: Nancy Huang D22F3BB7032946F...

Name: Nancy Huang

Title: CFO, CalOptima

Date: 02/06/2025

Signature: Signed by: Michael Hunn EDDDDCC19C894FB...

Name: Michael Hunn

Title: CEO

Date: 02/06/2025

If CONTRATOR is a corporation, two officer signatures or Corporate Resolution or Corporate Seal is required.

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Attachment A-1

Scope of Work

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.

Exhibit B-2

SOW #	Topic	Purpose of Deliverable	Format, if applicable	Time Frame	Estimated Hours	Cost
1.2	Network Strategy	Strategic advice on the design of the CalOptima Health Covered CA provider network	PowerPoint presentations, Network documents	Complete by February 28, 2025	80	31,900
1.3	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	55	19,700
	Knox Keene Licensure Filing Subject Matter Expertise	Review of specific licensure filing documents as needed.	Word, Excel	Complete by December 31, 2025	80	33,400
1.4	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	210	91,500
1.5	Support on Operational Requirements	Strategic advice on operational requirements that must be met by CalOptima Health to complete the QHP application to enroll and serve Covered California enrollees	PowerPoint presentations, meeting attendance	Complete by September 30, 2026	175	73,500
Total					600	$250,000

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 4, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

18. Approve the Establishment of the Legislative Committee as an Additional Standing Board Committee

Contacts

Veronica Carpenter, Chief Administrative Officer, (657) 650-9531
Michael Hunn, Chief Executive Officer, (714) 246-8570

Recommended Actions

1. Establish the Legislative Committee as an additional standing committee of the CalOptima Health Board of Directors in accordance with the recommendation from the Legislative Ad Hoc Committee;
2. Authorize the Chair of the Board of Directors to appoint up to three members of the Board of Directors to serve on the Legislative Committee and to appoint the Chair of the Legislative Committee; and
3. Establish a quarterly meeting cadence for the Legislative Committee with meetings to be held at 3 p.m. on the second Thursday of the appropriate month in each quarter.

Background/Discussion

On March 12, 1996, the CalOptima Health Board of Directors (Board) established two standing Board committees — the Finance and Audit Committee (FAC) and the Quality Assurance Committee (QAC) (see Attachment 1).

The Legislative Ad Hoc Committee was established on March 6, 2025, at a regular meeting of the Board. That committee, which consisted of Chair Isabel Becerra, Vice Chair Vicente Sarmiento, and Director Norma García Guillén, met monthly to address various legislative and advocacy issues related to CalOptima Health.

On September 4, 2025, the Legislative Ad Hoc Committee formally recommended that a standing Legislative Committee of the Board be established.

Staff recommends that CalOptima Health follow the same appointment process for the Legislative Committee as for the FAC and QAC committees. Currently, up to three Board members are appointed to each standing committee by the Chair of the Board. The Chair also appoints the chairs of the committees.

Staff also recommends a meeting schedule that is similar to FAC and QAC, which both meet on a quarterly basis, with meetings of the Legislative Committee to be held at 3 p.m. on the second Thursday of the appropriate month in each quarter.

Fiscal Impact

There is no fiscal impact.

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Rationale for Recommendation
This item officially establishes a standing Legislative Committee of the Board.

Concurrence
CalOptima Health Board Legislative Ad Hoc Committee
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Previous Board Action dated March 12, 1996, Approval of Establishment of Two Standing Board Committees

/s/ Michael Hunn *11/25/2025*
Authorized Signature **Date**

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CALOPTIMA BOARD AGENDA REFERRAL
Action To Be Taken March 12, 1996
Regular Meeting of the CalOPTIMA Board of Directors

Discussion Item
10 C. Approval of Establishment of Two Standing Board Committees

Contact
Mary Dewane, Chief Executive Officer
(714) 246-8400

Recommended Action
Establish two standing Board Committees, the Finance Committee and the Quality Assurance Committee, in accordance with the recommendations of the Ad Hoc Workgroup on Board Reorganization and a schedule for Committee meetings, and authorize the Board Chair to appoint Committee Members and Committee Chairs.

Background
A Board of Directors Ad Hoc Workgroup on Board Reorganization was appointed by Chairman Cochran. This Workgroup was directed to consider the transition and election of new Board Officers; an alternate meeting schedule for the Board; and the establishment of standing committees.

The CalOPTIMA Board of Directors maintains significant oversight responsibilities for the overall CalOPTIMA program. These responsibilities cover a wide range of issues from financial affairs to human resources to quality of care. In fulfilling these oversight responsibilities the Board is able to create standing Committees charged with focusing on specific areas of oversight interest and reporting back to the full Board of Directors. In conducting oversight duties, standing Committees may make recommendations for action to the full Board.

Discussion
The Ad Hoc Workgroup on Board Reorganization met to discuss a number of issues related to the function of the Board of Directors, and one of the issues discussed was increasing the Board's ability to focus on oversight and policy setting responsibilities. While the Workgroup recommended decreasing the number of full Board meetings, the Workgroup also envisioned the establishment of two standing Committees devoted to oversight and policy development.

Specifically, the Workgroup recommends that two distinct Committees be established, a standing Finance Committee and a standing Quality Assurance Committee. In general, the two Committees will consist of three Board members appointed by the Board Chair to serve a one year term. The Board Chair will designate the Committee Chairs who will

also serve one year terms. The Committees will be subject to the same open government practices that apply to the full Board, meaning that agendas will be set and posted and attendance and meeting minutes will be carefully monitored. For the purposes of Committee meetings, a quorum shall consist of two Committee members. In the event that a Committee member is unable to attend a given Committee meeting, the Board Chair has the option of participating in that meeting as a voting Committee member.

In regards to the specific charters of the two Committees, the Workgroup recommends the following:

Finance Committee

The Finance Committee is charged with oversight responsibilities for all financial matters affecting CalOPTIMA. This includes but is not limited to:

Budget development and approval;
Financial reporting;
Investment practices and policies;
Purchasing and procurement practices and policies;
Insurance issues;
Capitation and claims issues; and
Human resources issues.

The Committee would serve as the primary level of Board review for any finance-related issues or policies affecting the CalOPTIMA program. Because CalOPTIMA faces a continual flow of financial issues and because financial considerations are so important to the CalOPTIMA program, the Workgroup recommends that this Committee meet monthly. Further, this Committee should also make monthly reports to the full Board to summarizing the Committee's oversight activities for the month and making recommendations for necessary Board action.

Quality Assurance Committee

The Quality Assurance Committee is charged with oversight of policies and issues related to the overall quality of the CalOPTIMA program. Such oversight entails quality as it relates both to health care delivered under the CalOPTIMA program and to the quality of program operations itself. Specific oversight responsibilities will include but are not limited to:

Health care delivery quality and standards;
Health outcomes;
Operational performance standards; and
Quality improvement initiatives.

Because quality assurance will continue to be one of the most important goals of the Board, the Workgroup believes that these issues should be addressed by the Quality Assurance Committee through monthly meetings scheduled on the same day as the

monthly meetings of the Finance Committee. However, should urgent quality issues arise, the Quality Assurance Committee, like the Finance Committee and the full Board, will have the authority to convene a special meeting with limited notice to address immediate concerns.

Finally, given that the Workgroup recommended that the Board move to one monthly meeting, the second Tuesday of each month is now free for Committee meetings. The Workgroup also recommends that the attached schedule of Committee meetings be adopted taking advantage of the change in the full Board meeting schedule.

While the Board still retains significant oversight responsibilities, these responsibilities can be fulfilled through monthly meetings and through the advent of standing oversight committees that report directly to the Board.

Fiscal Impact
None.

Rationale for Recommendation
While the Board still retains significant oversight responsibilities, these responsibilities can be fulfilled through monthly meetings of the full Board and through the establishment of two standing oversight Committees that report directly to the Board.

Concurrence
Ad Hoc Workgroup on Board Reorganization

Attachments
Schedule of CalOPTIMA Board Committee Meetings

Authorized Signature

3/3/94
Date

SCHEDULE OF CALOPTIMA BOARD
FINANCE AND QUALITY ASSURANCE COMMITTEE MEETINGS

April 9, 1996

May 14, 1996

June 11, 1996

July 9, 1996

August 13, 1996

September 10, 1996

October 8, 1996

November 12, 1996

December 10, 1996

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

19. Adopt the Proposed CalOptima Health Board of Directors, Including the Finance and Audit, Quality Assurance and Legislative Committees, Meeting Schedule Effective January 1, 2026, through December 31, 2026

Contact

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

Recommended Action

Adopt the proposed meeting schedule of the CalOptima Health Board of Directors, the Finance and Audit Committee, the Quality Assurance Committee, and the Legislative Committee for Calendar Year 2026.

Background

Section 5.2(b) of the CalOptima Health Bylaws specifies that the Board of Directors (Board) shall conduct an annual organizational meeting at a regular meeting to be designated in advance by the Board. At the annual organizational meeting, the Board shall:

1. Adopt a schedule stating the dates, times, and places of the Board's regular meetings for the following year.
2. Organize itself by the election of one of its Directors as Chair and one as Vice Chair and by the election of such other officers as the Board may deem appropriate.

Discussion

The proposed schedule of meetings for the period of January 1, 2026, through December 31, 2026, is as follows:

1. The Board will meet at 2:00 p.m. on the first Thursday of each month, with the following exceptions:
   - Due to the New Year's holiday, staff recommends that the Board not meet in January. Should unanticipated items arise during January 2026 that require Board review/approval, the Chief Executive Officer will confer with the Board Chair or Vice Chair, and items will be presented for ratification at the following regularly scheduled Board meeting.

   - Due to the Independence Day holiday, staff recommends that the Board not meet in July. Should unanticipated items arise during July 2026 that require Board review/approval, the Chief Executive Officer will confer with the Board Chair or Vice Chair, and items will be presented for ratification at the following regularly scheduled Board meeting.

2. The Finance and Audit Committee (FAC) will meet at 3:00 p.m. on the third Thursday in the months of February, September and November and will meet on the fourth Thursday in May, due to the Governor's May Revise.

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3. The Quality Assurance Committee (QAC) will meet at 3:00 p.m. on the Third Thursday in the months of March, June, and December and will meet on the fourth Thursday in October.

4. The Legislative Committee (LC) will meet at 3:00 p.m. on the second Thursday in the months of March, June, September, and December.

5. The annual Organizational Meeting will be held at the regular meeting scheduled for December 3, 2026.

The meetings of the Board, the FAC, the QAC, and the LC are held at the CalOptima Health offices located at 505 City Parkway West, First Floor Conference Room, Orange, California, unless notice of an alternate location is provided.

The proposed Board of Directors Meeting Schedule is attached.

Fiscal Impact
The annual fiscal impact is approximately $21,800 in per diem costs and mileage reimbursement for Board and committee members or $10,900 for the six-month period. Funding for the period of January 1, 2026, through June 30, 2026, is included as part of the CalOptima Health Fiscal Year (FY) 2025-26 Operating Budget. Staff will include funding for the period on and after July 1, 2027, in the CalOptima Health FY 2026-27 Operating Budget.

Rationale for Recommendation
The recommended action will confirm the Board's meeting schedule for the next calendar year as required in Section 5.2 of the Bylaws and align with the Election of Officers going forward. The recommended action will also confirm the meeting schedule for the FAC, QAC, and LC for the next calendar year.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachment
1. Proposed Schedule of Meetings of the CalOptima Health Board of Directors, the Finance and Audit Committee, the Quality Assurance Committee, and the Legislative Committee for the Period of January 1, 2026 through December 31, 2026

/s/ Michael Hunn *11/25/2025*
Authorized Signature **Date**

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Board of Directors Meeting Schedule
Calendar Year 2026
January 1, 2026 -- December 30, 2026

All meetings are held at the following location, unless notice of an alternate location isprovided:
505 City Parkway West, First Floor Conference Room, Orange, California 92868

Board of Directors **Monthly – First Thursday** **Meeting Time: 2:00 p.m.**	**Finance and Audit Committee** **Quarterly – Third Thursday** **Meeting Time: 3:00 p.m.**	**Quality Assurance Committee** **Quarterly – Third Thursday** **Meeting Time: 3:00 p.m.**	**Legislative Committee** **Quarterly – Second Thursday** **Meeting Time: 3:00 p.m.**
January 2026^			
February 5, 2026	February 19, 2026		
March 5. 2026		March 19, 2026	March 12, 2026
April 2, 2026			
May 7, 2026	May 28, 2026[2]		
June 4, 2026		June 18, 2026	June 11, 2026
July 2026^			
August 6, 2026			
September 3, 2026	September 17, 2026		September 10, 2026
October 1, 2026		October 22, 2026[2]	
November 5, 2026	November 19, 2026		
December 3, 2026[1]		December 17, 2026	December 10, 2026

^No Regular meeting scheduled; [1]Organizational Meeting; [2]Fourth Thursday

DRAFT

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 4, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

20. Consider a Request to Support a Proposed Amendment to CalOptima Health's Governing Ordinance

Contact

Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Action

Consider a request to support a proposed amendment to CalOptima Health's governing ordinance regarding contracting with acute care hospitals.

Background

As a county-organized health system, CalOptima Health provides publicly-funded health care services to approximately 885,000 Medi-Cal beneficiaries living in Orange County – more than 1 in 4 residents. These services are delivered through a robust network of contracts with nearly 10,000 providers in every corner of the county. As of October 24, 2025, this includes 1,288 primary care providers, 7,728 specialists, 496 pharmacies, 42 acute care and rehabilitation hospitals, 71 community health centers, and 227 long-term care facilities.

On October 29, 2025, CalOptima Health received notification from the office of Orange County Supervisor Janet Nguyen regarding a proposed amendment to CalOptima Health's governing ordinance that would place additional stipulations regarding CalOptima Health's ability and discretion to contract with acute care hospitals in Orange County. The notification also requested CalOptima Health's consideration of supporting the amendment. The proposed amendment (Attachment 1) was originally scheduled for a first reading by the Orange County Board of Supervisors on November 4, 2025, at which time the first reading was continued to December 2, 2025, and a tentative second reading was scheduled for December 16, 2025.

CalOptima Health previously opposed a proposed state bill – Senate Bill (SB) 1268 (2024) authored by then-State Senator Janet Nguyen – that would have placed similar stipulations on all Medi-Cal managed care plans. At the time, it was determined that SB 1268 conflicted with the following priority in CalOptima Health's 2023-24 Legislative Priorities, as previously approved by the CalOptima Health Board of Directors (Board): "Remove barriers to provider contracting…" (see Attachment 4). SB 1268 was subsequently pulled from consideration. For reference, CalOptima Health's opposition letters to two amended versions of SB 1268 are included as Attachments 2 and 3.

Discussion

The proposed amendment to CalOptima Health's governing ordinance raises several questions as to its potential impact on the underlying purpose and structure of the managed care system that now largely governs the Medi-Cal program, which recognizes that some providers deliver higher quality

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and more cost-effective care. Prescribing contracting relationships and language in county ordinance could also impact the ability of CalOptima Health and acute care hospitals to negotiate and enter mutually agreeable terms in good faith. To that end, when determining whether to authorize or terminate provider contracts, CalOptima Health currently considers several factors, including a provider's quality of care, access and availability, accreditation statuses, non-compliance with regulatory requirements, existence of settlement or corporate integrity agreements, and engagement in fraud, waste, and abuse, including but not limited to anti-kickback schemes and the submission of false claims.

Placing additional stipulations on CalOptima Health's ability to consider such critical factors and other universally recognized credentialing standards could impact quality of care for CalOptima Health's members, as well as CalOptima Health's oversight and accountability over the expenditure of billions of dollars of taxpayer funds.

CalOptima Health's Fiscal Year 2025-26 Public Policy Priorities, as recently approved by the Board on October 2, 2025, continue to retain the following aforementioned priority: "Remove barriers to provider contracting…" (see Attachment 5).

Given that the proposed amendment to CalOptima Health's governing ordinance includes requiring Board authority to terminate an acute care hospital contract as well as 60-day advance written notice to the Orange County Board of Supervisors, staff is seeking Board direction on the proposed amendment.

Fiscal Impact
The recommended action has no fiscal impact.

Rationale for Recommendation
Considering the ordinance amendment affecting CalOptima Health's ability to contract with acute care hospitals may have a significant impact on access to and quality of care for all members.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Proposed Amendment to CalOptima Health's Governing Ordinance
2. CalOptima Health's Opposition Letter (dated April 15, 2024) to SB 1268 (2024), as amended on March 20, 2024
3. CalOptima Health's Opposition Letter (dated April 17, 2024) to SB 1268 (2024), as further amended on April 15, 2024
4. CalOptima Health's 2023–24 Legislative Priorities
5. CalOptima Health's Fiscal Year 2025–26 Public Policy Priorities

/s/ Michael Hunn *11/25/2025*
Authorized Signature **Date**

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ORDINANCE NO._____

AN ORDINANCE OF THE COUNTY OF ORANGE, CALIFORNIA, AMENDING SECTIONS 4-11-2, 4-11-7, AND 4-11-16 OF THE CODIFIED ORDINANCES OF THE COUNTY OF ORANGE, REGARDING CONTRACTING BY THE ORANGE COUNTY HEALTH AUTHORITY

The Board of Supervisors of the County of Orange ordains as follows:

SECTION 1. Sections 4-11-2, 4-11-7 and 4-11-16 of the Codified Ordinances of the County of Orange are hereby amended to read as follows:

Sec. 4-11-2. - Purpose.

(a) The purpose of the Health Authority is to negotiate exclusive contracts specified in Welfare and Institutions Code section 14087.5 with the California Department of Health Care Services and to arrange for the provision of health care services provided pursuant to chapter 7 of part 3 of division 9 of the Welfare and Institutions Code, and to participate in any other publicly supported health care program the Health Authority is permitted to participate in under state and federal law that are intended to assist low income or indigent residents in obtaining healthcare.

(b) The Health Authority shall design and operate a program that:

(1) Incorporates managed care concepts; gives high priority to prevention, education and early intervention services; and improves access to primary care and related specialty and ancillary services for enrolled recipients.

(2) Includes mechanisms for assuring that the program is culturally appropriate and linguistically competent, provides for continuity of care and geographic access to health care services, and meets appropriate quality of care standards.

(3) Recognizes the importance of institutions providing medical, nursing and allied health education.

(4) Provides a system for enrolled recipients to select their primary care provider.

(5) Includes special care management components and a system of assignment to such components assuring that the health care needs of enrolled recipients with special requirements are met.

(6) Incorporates a plan of service delivery and implements reimbursement mechanisms which will assure the long-term viability of a locally operated Medi-Cal managed care system and maintain access to all acute care hospitals for Medi-Cal recipients in the County of Orange.

(7) Implements a financial plan which includes the creation of a prudent reserve within three

years of commencing operation, and which provides that if additional surplus funds accrue, such funds shall be used to expand access, improve benefits and/or augment provider reimbursement.

(8) Includes mechanisms that protect against arbitrary or capricious formation and termination of contracts.

~~(8)~~(9) Ensures that all program obligations, statutory, contractual or otherwise, shall be obligations of the program and shall not be the obligations of the County of Orange.

(c) The Health Authority shall have the power to contract with providers for services, including, but not limited to, contracts where services are provided on a capitation and other risk-sharing basis. The Health Authority may contract with public and private insurers, purchasers of health insurance, and fiscal intermediaries to administer its health care program.

(d) After commencement of operations of the Health Authority finance program for Medi-Cal recipients, the Health Authority shall design and implement a plan through separate contracts to include within the program it administers those eligible indigent persons for whom the County of Orange is responsible under part 5 (commencing with section 17000) of division 9 of the Welfare and Institutions Code. Unless otherwise provided by the Health Authority, providers contracting with the Health Authority shall serve all CalOptima eligible populations.

(e) The Health Authority shall have the power to contract with the California Managed Risk Medical Insurance Board, or other state approved Board as a participating health plan under California's Healthy Families Plan (part 6.2 of division 2 of the Insurance Code, commencing with section 12693).

(f) The Health Authority shall have the power to contract with the Centers for Medicare & Medicaid Services, or other applicable federal or state approved organization, and to execute such other agreements and documents to effectuate health care delivery systems for any of the following persons:

(1) Persons who are eligible to receive medical benefits under both Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) and Title 19 of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(2) Persons who are eligible to receive medical benefits under Title 18 of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.); and

(3) Other individuals or groups in the service area, including, but not limited to, public agencies, private businesses, and uninsured or indigent persons. The Health Authority shall not use any payment or reserve from Medi-Cal program for purposes of this subparagraph.

(g) The Health Authority shall have the power to enter into contracts for provision of health care services to individuals in the service area who are eligible to receive medical benefit under any publicly supported program, such as Medi-Cal and Healthy Families, if the following

requirements are both met:~~, but only if the Health Authority and participating providers acting pursuant to subcontracts with the Health Authority agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the Health Authority does not ensure sufficient funding to cover program costs. The Health Authority shall not use any payments or reserve from the Medi-Cal program for this purpose.~~

(1) The Health Authority and participating providers acting pursuant to subcontracts with the Health Authority agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the Health Authority does not ensure sufficient funding to cover program costs. The Health Authority shall not use any payments or reserve from the Medi-Cal program for this purpose.

(2) The Health Authority shall offer all acute care hospitals designated by the Orange County Emergency Medical Services as emergency receiving centers and physically located and operating within the County of Orange, a network contract for emergency and post-stabilization care, on the same terms and conditions as the Health Authority requires for these services from other acute care hospitals. The Health Authority shall maintain network contracts, containing those same terms and conditions for these services, with all acute care hospitals designated by the Orange County Emergency Medical Services as emergency receiving centers who accept that offer.

(A) Notwithstanding the requirements of this subsection (g)(2), the Health Authority may offer a network contract with different terms and conditions as the Health Authority requires from other acute care hospitals upon an affirmative vote of the Health Authority's governing body and 60 calendar days' advance written notice to the Orange County Board of Supervisors.

(B) Notwithstanding the requirements of this subsection (g)(2), the Health Authority may terminate, and not maintain, a network contract with an acute care hospital designated by the Orange County Emergency Medical Services as emergency receiving centers, upon an affirmative vote of the Health Authority's governing body and 60 calendar days' advance written notice to the Orange County Board of Supervisors.

(g) ~~(h)~~ The Health Authority shall have the power to participate in the California Health Benefit Exchange (commonly known as Covered California) as a health care service plan in accordance with Title 22 of the California Government Code (commencing with Section 100500) and Title 10 of the California Code of Regulations. The Health Authority shall have the power to participate in any other publicly supported health care program that the Health Authority is permitted to participate in under state and federal law that are intended to assist low income or indigent residents in obtaining healthcare. Nothing in this subsection (h) shall be construed to limit the power of the Health Authority to enter into contracts for the programs described in subsections (a) through (g) of this section. Nothing in this subsection (h) shall limit the Health Authority from coordinating the referral of Orange County residents who have applied to a Health Benefit Exchange and are eligible for enrollment in the Medi-Cal, Healthy Families or other similar programs authorized by state or federal law for low income or indigent persons offered by the Health Authority.

~~(g)~~(h) Subject to state and federal laws, any authorized representative of the County of Orange

may, in coordination with the governing body of the Health Authority, be provided access to such books, documents, or records as are reasonably necessary to review the Health Authority's compliance with Section 4-11-2. A copy of the findings from any such review shall be provided to the governing body of the Health Authority.

Sec. 4-11-7. - Restrictions.

(a) Any contract entered into by the Health Authority shall contain a provision that any Health Authority obligation created by the contract shall not be an obligation of the County of Orange.

(b) Subject to state and federal laws, any authorized representative of the County of Orange shall be given access to any books, documents or other records of the Health Authority pertinent to the enforcement of this section.

Section 4-11-16 – Findings; conflict of interest.

(a) Pursuant to Welfare and Institutions Code section 14087.57(a) and section 18707.4 .of title 2 of the California Code of Regulations, it is determined that health care providers appointed to the Board of Directors of the Health Authority are intended to represent and further the interest of a health care industry, trade or profession, and that such representation and furtherance will ultimately serve the public interest. Accordingly, it is determined that for purposes of health care providers who are members of the Board of Directors of the Health Authority, a health care industry, trade or profession is tantamount to and constitutes the public generally within the meaning of section 87103 of the California Government Code.

(b) As used in this section, "health care industry, trade or profession" shall mean physicians, health care practitioners, hospitals, pharmacies, or other health care organizations, including managed care organizations, and trade or professional associations.

(c) A member of the Health Authority Board of Directors shall not be deemed to be interested in a contract entered into by the Health Authority within the meaning of article 4 (commencing with section 1090) of chapter 1 of division 4 of title 1 of the Government Code if all of the requirements set forth in Welfare and Institutions Code section 14087.57 are satisfied.

~~(b)~~(d) Subject to state and federal laws, any authorized representative of the County of Orange may, in coordination with the governing body of the Health Authority, be provided access to such books, documents, or records as are reasonably necessary to review the Health Authority's compliance with Section 4-11--16. A copy of the findings from any such review shall be provided to the governing body of the Health Authority.

CalOptima Health
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April 15, 2024

The Honorable Richard D. Roth
Chair, Senate Health Committee
1021 O Street, Room 3310
Sacramento, CA 95814

RE: Senate Bill (SB) 1268 (Nguyen) — OPPOSE

Dear Chairman Roth:

CalOptima Health must regretfully oppose SB 1268. As a county-organized health system, CalOptima Health provides publicly-funded health care services to more than 930,000 Medi-Cal beneficiaries living in Orange County — nearly 1 in 3 residents. We deliver these services through a robust network of contracts with more than 11,000 providers in every corner of the county. As of February 29, 2024, this includes 1,232 primary care providers, 9,465 specialists, 553 pharmacies, 39 acute care and rehabilitation hospitals, 52 community health centers, and 112 long-term care facilities.

SB 1268 would prohibit contracted safety-net providers and Medi-Cal managed care plans (MCPs), such as CalOptima Health, from terminating their contracts without stating the "cause" of the termination. For any contract termination, the "cause" could not be based on any material fact or condition known to both parties and which existed at the time the contract was effectuated. If signed into law, this bill would significantly disrupt the ability for both Medi-Cal MCPs and providers to negotiate and enter mutually agreeable contracts in good faith. It would also create an unlevel playing field by requiring a two-tiered contracting system for safety-net and non-safety-net providers — on top of the administrative burdens of potentially re-negotiating thousands of existing contracts. Moreover, this bill would likely lead to costly litigation and expenditure of Medi-Cal resources better used to serve Medi-Cal beneficiaries, given that what was known and what existed at the time of a contract negotiation could — and likely would be — argued to one side's advantage. In addition, since standard provider contracts do not typically include expiration dates, a Medi-Cal MCP's board of directors would be obligated to the actions of past boards, regardless of the evolving needs and circumstances of its members, communities and provider networks.

Prescribing contract language in state statute would impede thousands of health care entities across California from negotiating and entering future contracts, likely reducing total network availability and risking access to care for millions of Medi-Cal beneficiaries throughout the state. For these reasons, CalOptima Health must oppose SB 1268.

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Sincerely,

Michael Hunn
Chief Executive Officer

CC: Members, Senate Health Committee
Jen Flory, Principal Consultant, Senate Health Committee
Tim Conaghan, Policy Consultant, Senate Republican Caucus
Joe Parra, Policy Consultant, Senate Republican Caucus

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April 17, 2024

The Honorable Richard D. Roth
Chair, Senate Health Committee
1021 O Street, Room 3310
Sacramento, CA 95814

RE: Senate Bill (SB) 1268 (Nguyen) — OPPOSE

Dear Chairman Roth:

CalOptima Health must regretfully continue to oppose SB 1268, as amended on April 15, 2024. As a county-organized health system, CalOptima Health provides publicly-funded health care services to more than 930,000 Medi-Cal beneficiaries living in Orange County — nearly 1 in 3 residents. We deliver these services through a robust network of contracts with more than 11,000 providers in every corner of the county. As of February 29, 2024, this includes 1,232 primary care providers, 9,465 specialists, 553 pharmacies, 39 acute care and rehabilitation hospitals, 52 community health centers, and 112 long-term care facilities.

SB 1268 would mandate Medi-Cal managed care plans (MCPs), such as CalOptima Health, to contract with all willing safety-net providers under the same terms and conditions of similar providers in their respective service areas. A contract could only be terminated if a provider's license is revoked or suspended or if the California Department of Health Care Services (DHCS) determines a specific provider to be a threat to patient health. If signed into law, this bill would fundamentally undermine the purpose and structure of the "managed care" system that now largely governs the Medi-Cal program, which recognizes that some providers deliver higher quality and more cost-effective care. SB 1268 would also significantly disrupt the ability for both Medi-Cal MCPs and providers to negotiate and enter mutually agreeable terms in good faith, create an unlevel playing field with a two-tiered contracting system for safety-net and non-safety-net providers, and destabilize provider networks by potentially requiring the re-negotiation of thousands of existing contracts that vary by provider. Moreover, the bill's proposed definition of safety-net provider is ambiguous and open to legal interpretation.

Perhaps most concerning is the removal of any and all reasons for a Medi-Cal MCP to initiate a contract termination. In doing so, Medi-Cal MCPs would be prohibited from assessing a provider's quality of care, access and availability, accreditation statuses, non-compliance with regulatory requirements, existence of settlement or corporate integrity agreements, and engagement in fraud, waste, and abuse, including but not limited to anti-kickback schemes and the submission of false claims. Ignoring such critical factors and other universally recognized credentialing standards would risk the well-being of millions of Medi-Cal beneficiaries and remove oversight and accountability over the expenditure of billions of dollars of taxpayer funds. DHCS would not have the ability or capacity to assume such MCP

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responsibilities and evaluate thousands of providers to make contracting determinations at the level of patient risk dictated in the proposed language. As such, this bill would likely lead to unnecessary and costly litigation and expenditure of Medi-Cal resources better used to serve vulnerable beneficiaries.

Prescribing contracting relationships and language in state statute would impede thousands of health care entities across California from negotiating such contracts as well as risk the quality of care for millions of Medi-Cal beneficiaries throughout the state. For these reasons, CalOptima Health must continue to oppose SB 1268.

Sincerely,

Michael Hunn
Chief Executive Officer

CC: Members, Senate Health Committee
Jen Flory, Principal Consultant, Senate Health Committee
Tim Conaghan, Policy Consultant, Senate Republican Caucus
Joe Parra, Policy Consultant, Senate Republican Caucus

2023–24 Legislative Priorities

Behavioral Health

- Support improved parity between physical and mental health care, including rates and coverage of preventive services without diagnoses.
- Support stable, sustainable funding streams for behavioral health services.
- Increase funding for Medi-Cal member access to Be Well Orange County campuses.
- Remove barriers to accessing behavioral health services, including mobile crisis and telehealth-only.
- Incentivize all applicable providers to treat behavioral health conditions within their scope of service.
- Improve the system and capacity for complex discharge management of members with behavioral health diagnoses.
- Enhance integration between specialty and non-specialty Medi-Cal mental health services.
- Support policies to prevent and address substance use disorders, including medication access.

California Advancing and Innovating Medi-Cal (CalAIM)

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

Data Sharing

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

Financing

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

Older Adults

- Promote overall integration of the Medi-Cal and Medicare programs.
- Support enrollment of full and partial dual-eligible beneficiaries into exclusively aligned enrollment Dual Eligible Special Needs Plans (EAE D-SNPs).
- Align Medi-Cal and Medicare policies that limit the frequency of plan switching to improve continuity of care.
- Support the creation and sustainability of Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) consistent with EAE D-SNP enrollment policies.
- Expand access to home- and community-based services, including the Program of All-Inclusive Care for the Elderly (PACE), for older adults, including those experiencing or at risk of homelessness.

- Preserve current flexibilities to virtually assess prospective and current PACE participants.
- Expand onsite access to COVID-19 vaccines at PACE facilities.
- Allow PACE organizations to utilize ride-sharing services to supplement transportation vendors.
- Increase PACE funding to address telehealth barriers, such as member access to devices, internet and training.

Operations and Administration

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

Provider Support

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

Quality Improvement

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

Social Determinants of Health (SDOH)

- Support policies, funding and flexibility to address SDOH, such as housing, transportation and food insecurity.
- Support the construction and permitting of supportive housing and recuperative care facilities.
- Remove barriers to Medi-Cal enrollment, services and access to care for individuals experiencing homelessness.
- Improve collection and sharing of SDOH and demographic data across public agencies, health plans, utility providers and community-based organizations.

Fiscal Year 2025–26 Public Policy Priorities

Access to Care

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

Behavioral Health

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

California Advancing and Innovating Medi-Cal (CalAIM)

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

Data Sharing

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

Older Adults

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

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

Operations and Administration

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

Provider Support

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

Quality Improvement

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

Safety Net Funding and Financing

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

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

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item
21. Election of Officers of the Board of Directors for Terms Beginning January 1, 2026

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, 2026, 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 other committees except for 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
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Ballot for Election of Chair
2. Ballot for Election of Vice Chair

/s/ Michael Hunn *11/25/2025*
Authorized Signature **Date**

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BOARD OF DIRECTORS' ELECTION OF OFFICERS

CALENDAR YEAR 2026

VOTING BALLOT

CHAIR

VOTING DIRECTOR'S NAME: _____

	ISABEL BECERRA
	MAURA BYRON
	DOUG CHAFFEE
	BLAIR CONTRATTO
	NORMA GARCÍA GUILLÉN
	CATHY GREEN, R.N.
	BRIAN HELLELAND
	VERONICA KELLEY, DSW, LCSW
	JOSE MAYORGA, M.D.
	VICENTE SARMIENTO

Legend: Directors who received nominations for Chair or Vice Chair ahead of the December 4, 2025 Board meeting are **bolded** and **highlighted** above.

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BOARD OF DIRECTORS' ELECTION OF OFFICERS

CALENDAR YEAR 2026

VOTING BALLOT

VICE CHAIR

VOTING DIRECTOR'S NAME: _____

	ISABEL BECERRA
	MAURA BYRON
	DOUG CHAFFEE
	BLAIR CONTRATTO
	NORMA GARCÍA GUILLÉN
	CATHY GREEN, R.N.
	BRIAN HELLELAND
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Legend: Directors who received nominations for Chair or Vice Chair ahead of the December 4, 2025 Board meeting are **bolded** and **highlighted** above.

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