NOTICE OF A
REGULAR JOINT MEETING OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS'
MEMBER ADVISORY COMMITTEE AND
PROVIDER ADVISORY COMMITTEE

THURSDAY, APRIL 9, 2026

12:00 P.M.

CALOPTIMA HEALTH
505 CITY PARKWAY WEST, SUITE 109
ORANGE, CALIFORNIA 92868

AGENDA

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(s) identifying the item(s) and submit to the Clerk. To speak on a matter not appearing on the agenda, but within the subject matter jurisdiction of the Board of Directors' Member Advisory and Provider Advisory Committees, you may do so during Public Comments. Public Comment Request Forms must be submitted prior to the beginning of the Approval of the Minutes portion of the agenda and/or the beginning of Public Comments. When addressing the Committee, it is requested that you state your name for the record. Address the Committee as a whole through the Chair. Comments to individual Committee 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 of Directors' Regular Member Advisory and Provider Advisory Committees' joint meeting agenda and supporting materials are available for review at CalOptima Health, 505 City Parkway West, Orange, CA 92868, from 8 a.m. to 5:00 p.m., Monday through Friday, and online at www.caloptima.org.

Register to Participate via Zoom at:
https://us02web.zoom.us/webinar/register/WN_iWOX5t1WTpyPgcZMgnR9ng and join the meeting.

Webinar ID: 863 6348 6972

Passcode: **071718 – Webinar instructions are provided below.**

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

2. **ESTABLISH QUORUM**

3. **MINUTES**
   A. Approve Minutes from the February 11, 2026 Regular Joint Meeting of the Member and Provider Advisory Committees

4. **PUBLIC COMMENT**
   At this time, members of the public may address the Member and Provider Advisory Committees on matters not appearing on the agenda, but within the subject matter jurisdiction of the Member or Provider Advisory Committees. Speakers will be limited to three (3) minutes.

5. **INFORMATIONAL ITEMS**
   A. Policy Updates to Medi-Cal and CalFresh Programs
   B. Home and Community-Based Alternatives
   C. Health Equity Update
   D. Committee Member Update

6. **MANAGEMENT REPORTS**
   A. Government Affairs Update
   B. Chief Medical Officer Report

7. **COMMITTEE MEMBER COMMENTS**

8. **ADJOURNMENT**

Webinar Information

Please register for the Regular Member Advisory and Provider Advisory Committees Joint Meeting on Thursday, April 9, 2026, at 12:00 p.m. (PDT)

To register in advance for this webinar:

https://us02web.zoom.us/webinar/register/WN_iWOX5t1WTpyPgcZMgnR9ng
Join from a PC, Mac, iPad, iPhone or Android device

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Passcode: 071718

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MINUTES

REGULAR JOINT MEETING OF THE CALOPTIMA HEALTH BOARD OF DIRECTORS' MEMBER ADVISORY COMMITTEE, AND PROVIDER ADVISORY COMMITTEE

February 11, 2026

A Regular Joint Meeting of the CalOptima Health Board of Directors Member Advisory Committee (MAC) and Provider Advisory Committee took place on February 11, 2026, at CalOptima Health, located at 505 City Parkway West, Orange, California. The meeting occurred in person and via Zoom webinar, as permitted under the Brown Act, as amended by Senate Bill 707 (2025).

CALL TO ORDER

PAC Vice-Chair Gio Corzo called the meeting to order at 12:10 p.m. and led the group in the Pledge of Allegiance.

ESTABLISH QUORUM

Member Advisory Committee

Members Present: Meredith Chillemi, Vice-Chair; Linda Adair ; Sandy Finestone; Keiko Gamez; Kim Goll; Peter Hersh; Hai Hoang; Paul Kaiser; Sara Lee (12:10 p.m.); Lee Lombardo; Nicole Mastin; Jila Nikkhah, DDS; Kristen Rogers (remote)

Members Absent: Christine Tolbert, Chair; Tawny Crane; Dr. Junie Lazo-Pearson; Janis Price; Shirley Valencia

Provider Advisory Committee

Members Present: Gio Corzo, Vice Chair; Lorry Belhumeur, Ph.D.; Andrew Inglis, M.D.; Jena Jensen; Morgan Mandigo, M.D.; Tom Megerian, M.D.; Patty Mouton (12:15 p.m.); Mary Pham, Pharm.D.

Members Absent: John Nishimoto, O.D., Chair; Alpesh Amin, M.D; Tiffany Chou, NP; Alex Rossel; Jacob Sweidan, M.D.; Christy Ward

Others Present

Staff Present: Yunkyung Kim, Chief Operating Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Veronica Carpenter, Chief Administrative Officer; Michaell S. Rose, DrPH, LCSW, Chief Health Equity Officer; Carmen Katsarov, Executive Director, Behavioral Health; Linda Lee, Executive Director, Quality Improvement; Cheryl Simmons, Staff to the Advisory Committees; Ruby Nunez, Executive Assistant

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MINUTES

Approve the Minutes of the October 9, 2025, Regular Joint Meeting of the CalOptima Health Board of Directors' Member Advisory and Provider Advisory Committees

MAC Action: ***On motion of MAC Member Sandra Finestone, seconded and carried, the Committee approved the minutes of the October 9, 2025, Regular Joint Meeting (Motion carried 13-0-0; Members Christine Tolbert, Chair; Tawny Crane; Dr. Junie Lazo-Pearson; Janis Price; Shirley Valencia absent)***

At this time, PAC Vice-Chair Gio Corzo rearranged the agenda to hear public comments and information item A while waiting for a PAC member to achieve quorum.

PUBLIC COMMENTS

There were no public comments.

INFORMATION ITEMS

Behavioral Health Services Act and Updates

Carmen Katsarov, Executive Director of Behavioral Health, introduced Dawn Smith, LCSW, Assistant Deputy Director of Behavioral Health Services at the Orange County Health Care Agency. Ms. Smith explained the Behavioral Health Services Act (BHSA), including the history of Proposition 1, BHSA's goals and target populations, fiscal restructuring, funding categories, reporting and planning requirements, and community involvement opportunities. The Mental Health Services Act (MHSA), enacted in 2004 and implemented in 2005, was financed by a 1% tax on individuals earning over $1 million annually. In March 2024, California voters approved Proposition 1, a bond measure aimed at addressing homelessness and modernizing the behavioral health system, marking a major revision to the MHSA after nearly twenty years.

The Department of Health Care Services (DHCS) has strengthened California's behavioral health system through the BHSA, replacing the MHSA. These reforms aim to increase transparency, unify services, and expand care. Key changes include restructuring funding categories, adding a housing component, removing county-level prevention funding, and broadening eligibility to include substance use disorder services. Oversight of innovation now falls under the Behavioral Health Services Oversight and Accountability Commission. The state also increased its allocation from 5% to 10%, with the extra funds designated for statewide prevention planning and competitive grants. Ms. Smith also highlighted that a major change is reflected in the new three-year integrated plan, which requires counties to report on all funding sources and programs, thereby improving transparency but increasing documentation requirements. The behavioral health continuum now includes early intervention, outpatient and crisis care, inpatient and long-term services, and housing. Health equity is integrated across BHSA goals, with counties focusing on six priority areas and

selecting one additional focus. Orange County decided to prioritize the prevention and treatment of co-occurring physical health conditions.

The BHSA updates California's behavioral health system by adding housing and expanding services to include substance use disorders. It introduced a three-year integrated plan that requires comprehensive reporting on all funding and programs, incorporates health equity goals, and prioritizes high-need populations like homeless individuals, justice-involved youth, and those at risk of institutionalization. Funding is now divided into 30% for housing, 35% for full-service partnerships with mandated evidence-based practices, and 35% for behavioral health supports, including early intervention for youth. The plan promotes transparency, accountability, and collaboration with managed care and community stakeholders.

Amanda McConnell, Manager of Behavioral Health, explained how CalOptima Health offers behavioral health services for members with mild to moderate impairments, while Orange County Behavioral Health manages severe conditions. This creates a split system based on impairment level rather than diagnosis. She noted that collaboration between these two organizations is strong, supported by shared screening tools, real-time data sharing, and closed-loop referrals, which ensure smooth transitions and help prevent care gaps.

Ms. McConnell emphasized that CalOptima Health provides services like psychotherapy, psychiatry, medication management, neuropsychological testing, substance use screening, and Applied Behavioral Analysis (ABA) therapy for members under 21. It also offers newer benefits such as Transcranial Magnetic Stimulation (TMS) and dyadic services. For OneCare members, additional services include inpatient care, intensive outpatient programs (IOP), and partial hospitalization programs (PHP). Access to these services is available through a dedicated behavioral health line, an online provider search, telehealth options, and member liaison specialists who assist with scheduling and follow-up to ensure proper connection to care. Ms. McConnell also highlighted that the focus remains on accessibility, coordination, and member choice, with multiple ways to access services and strong collaboration between managed care and county behavioral health systems.

At this point, Vice-Chair Corzo resumed the approval of the PAC minutes before moving on with the rest of the agenda.

Approve the Minutes of the December 11, 2025, Regular Joint Meeting of the CalOptima Health Board of Directors' Member Advisory and Provider Advisory Committees

MAC Action: The MAC did not achieve quorum in the room at this meeting as per Brown Act Rules at the December 11, 2025 meeting.

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PAC Action: ***On motion of PAC Member Dr. Mandigo, seconded and carried, the Committee approved the minutes of the December 11, 2025, Regular Joint Meeting (Motion carried 8-0-0; Members John Nishimoto, O.D., Chair; Alpesh Amin, M.D; Tiffany Chou, NP; Alex Rossel; Jacob Sweidan, M.D.; Christy Ward absent).***

Committee Member Updates

MAC Vice-Chair Meredith Chillemi welcomed new MAC members: Jila Nikkhah, DDS, as a Dental Provider Representative; Janis Price as the Local Education Agency Representative; and Kristen Rogers as a Medi-Cal Authorized Family Member.

Vice-Chair Chillemi also notified the MAC that recruitment for seats with terms ending on June 30, 2026, has started, and Cheryl Simmons, Staff to the Advisory Committees, will reach out to members whose terms expire after the meeting. She also asked the MAC for help in recruiting for open seats.

She also asked eligible committee members to kindly complete their stipend forms and return them to Cheryl Simmons. Additionally, she reminded the MAC that if they had any agenda items to discuss, they should notify Cheryl Simmons as well.

PAC Vice-Chair Gio Corzo also informed PAC members that recruitment had begun and that Cheryl Simmons would notify them if they were eligible to reapply for their seats.

CEO AND MANAGEMENT REPORTS

Chief Medical Officer Report

Richard Pitts, D.O., Ph.D., Chief Medical Officer, provided a brief update on the rising measles cases. He pointed out that CalOptima Health's members now live in an era of "magic medicine," where breakthroughs like antibiotics, immunizations, statins, and now GLP-1 drugs have enhanced health outcomes. These advancements have lowered the occurrence of childhood disease outbreaks and improved chronic disease management, but they also come with unintended side effects. A major concern is the growing number of immunocompromised individuals who are highly vulnerable to infections like measles.

Dr. Pitts explained that measles is highly contagious, with a 90% infection rate after exposure, and people can spread the virus before the rash appears. Recent outbreaks in the U.S. are linked to international travel and areas with low vaccination rates. Cases have increased from 59 in 2023 to nearly 2,800 in 2025, with active outbreaks in states like South Carolina. In California, although 95% of school-age children are vaccinated, some communities remain unprotected, increasing the risk of further spread.

He also noted that healthcare systems face challenges as pediatric bed capacity has decreased, and urgent care centers often lack immunization requirements for their staff. A major outbreak could

overwhelm resources and threaten vulnerable populations, especially pregnant women, for whom measles can cause severe complications. Dr. Pitts explained that public health experts emphasize that vaccines are safe and essential, with no connection to autism. He urged everyone to serve as ambassadors for immunization, promote vaccination, and ensure that urgent care staff are protected to prevent a potential health crisis.

Chief Administrative Officer Update

Veronica Carpenter, Chief Administrative Officer, noted that at the February 10, 2026, Board of Supervisors meeting, Chairman Chaffee confirmed his appointments to the CalOptima Health Board of Directors. Supervisor Sarmiento will continue serving as a regular Board Member and Chair, and Supervisor Janet Nguyen will rejoin the Board as a regular Board Member in March. She previously served for nearly a decade, most recently as an Alternate Member of the CalOptima Health Board of Directors. Supervisor Chaffee will now assume the role of Alternate Member on the CalOptima Health Board.

Ms. Carpenter also discussed HR 1 and noted that DHCS had released a detailed implementation plan outlining communication strategies and priorities for the upcoming year. She mentioned that CalOptima Health's government affairs team condensed the 58-page document into a two-page summary, which will be shared with committee members. Additionally, DHCS plans to start sending text messages this month to Medi-Cal members in the modified adjusted gross income group. These messages will introduce upcoming requirements, including work obligations and six-month renewals, and will be sent semiannually to prepare members for changes beginning next year. CalOptima Health will also gather and share further legislative updates to ensure all committee members stay informed.

Chief Executive Officer Update

Michael Hunn, Chief Executive Officer, stated that enrollment has decreased significantly, with about 50,000 members lost over the past 11 months and 12,000 in just the last month. Current membership is around 865,000, down from 877,000. At this pace, CalOptima Health could lose an additional 100,000 covered lives by the end of the fiscal year. He explained that a major issue is renewal challenges, especially among undocumented populations and households with mixed statuses, where parents may avoid re-enrollment for eligible children due to fears of data sharing. This results in children missing well-child visits, immunizations, and developmental screenings, all of which pose long-term health risks.

The most urgent issue is losing access to medications for chronic conditions like diabetes, heart disease, liver disease, and Parkinson's. Without coverage, members can't afford prescriptions, which can lead to serious health problems. Urgent care centers and emergency rooms only provide limited solutions because they either charge for prescriptions or only dispense emergency medications. This care gap could escalate into a public health crisis, especially for vulnerable groups such as children and seniors who lack Medi-Cal coverage.

CalOptima Health manages care for about 60% of children in Orange County, including 350,000 members aged 0–21 and 75,000 under age five. A drop in enrollment could lead to more serious health problems among remaining members and increase the burden on emergency services at children's hospitals across the region. To address this, CalOptima Health is collaborating with county partners and creating a comprehensive communication toolkit that includes FAQs, posters, and social media content to help members understand HR 1 requirements and renewal processes. Community cooperation and proactive outreach are essential to reducing these risks.

Mr. Hunn also discussed how the rules and exceptions related to behavioral health and similar requirements are complex and often confusing. He mentioned that to address this, CalOptima Health is creating simplified, standardized materials for all its partners to use. These resources will promote consistent messaging across all access points, whether members contact the county, Social Services Agency, 211, or CalOptima Health. The goal is for everyone to receive the same accurate information. As these materials are developed, Veronica Carpenter, Chief Administrative Officer, will share drafts for review. Feedback is essential for identifying unclear language, missing details, or unnecessary content so we can improve the messaging. These resources will then be distributed to the MAC and PAC for input. He also emphasized the important role of committee members, noting that they serve as the community's eyes and ears, helping ensure clarity and accuracy.

Mr. Hunn also mentioned that DHCS auditors were on-site for the annual audit and that CalOptima Health remains committed to showing accountability and compassion for its members. He emphasized that collaboration is vital and that committee members' questions and insights continue to help CalOptima Health provide consistent, respectful communication.

Mr. Hunn finished his update by thanking the members for their time and cooperation in this effort.

ADJOURNMENT

With no further business before the Committees, PAC Vice-Chair Gio Corzo adjourned the meeting at 2:03 p.m. and reminded members that the next meeting is scheduled for Thursday, April 9, 2026.

Cheryl Simmons
Staff to the Advisory Committees

Policy Updates to Medi-Cal and CalFresh Programs

COUNTY OF ORANGE CALIFORNIA
SocialServicesAgency
Our Community, Our Commitment

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Disclaimer: The details contained in this presentation are subject to change as official guidance is issued.

Medi-Cal and CalFresh Policy Change Timeline

2026

Medi-Cal - January 1
Reinstated asset limits for older adults and people with disabilities

Full-scope enrollment freeze for undocumented adults

CalFresh – April 1
Several categories of noncitizens excluded from CalFresh eligibility

CalFresh – June 1
Re-established work requirements for Able-Bodied Adults Without Dependents (ABAWD) ages 18-64

Medi-Cal - July 1
Full-scope dental coverage eliminated for undocumented adults age 19+

Medi-Cal – October 1
Certain individuals are no longer recognized as Qualified Noncitizens

2027

Medi-Cal - January 1
Most adults ages 19-64, regardless of immigration status, must meet work requirements or prove they are exempt to keep their coverage

Most adults ages 19-64, regardless of immigration status, are required to renew every 6 months

Retroactive coverage period shortened for all Medi-Cal applicants

Medi-Cal - July 1
Premium requirements for undocumented adults ages 19-59 receiving full-scope Medi-Cal

2028

Medi-Cal - October 1
Co-payment requirements for certain health care services for most adults ages 19-64, regardless of immigration status

OC Social Services Agency

Disclaimer: The details contained in this presentation are subject to change as official guidance is issued.

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Medi-Cal and CalFresh Policy Terms

- **Full Scope Medi-Cal** - provides low-income individuals and families with a wide range of medical services, including doctor's visits, hospitalizations, dental care, vision care, mental health care and prescription drugs.

- **Restricted Scope Medi-Cal** - provides emergency services and pregnancy-related care to people who are not eligible for full scope Medi-Cal but who meet other program requirements.

- **Asset Limit** - maximum value of countable resources a person can own.

- **Affordable Care Act (ACA) Expansion Population** - low-income 19-64 adults, particularly childless adults, who become eligible for Medi-Cal if their income is at or below 138% of the federal poverty level.

- **Able-Bodied Adults Without Dependents (ABAWD)** - CalFresh recipients aged 18-64 who are subject to a work requirement and time limit for receiving benefits.

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Medi-Cal Policy Updates

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Disclaimer: The details contained in this presentation are subject to change as official guidance is issued.

Medi-Cal Asset Check

Effective January 1, 2026

Policy Change

Medi-Cal will begin checking what applicants and recipients own

Affected Group

- Adults 65 and older
- People with disabilities
- People that are part of a family that is over the income for Medi-Cal using federal tax rules
- Those in nursing homes

Asset Limits

- $130,000 for one person
- $65,000 for each additional household member (up to 10 people)

Countable Assets Include But Not Limited To

- Bank accounts
- Cash
- More than one house or vehicle

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Medi-Cal Enrollment Freeze for Undocumented Adults – Effective January 1, 2026

Affected Group

Adults age 19 who are undocumented

Key changes

- New enrollments frozen for full-scope Medi-Cal
- New applicants are limited to restricted Medi-Cal, which covers only emergency services

Exemptions

- Children under 19
- Pregnant individuals eligible to full-scope services during pregnancy and one year postpartum

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Dental Benefits Update

Effective July 1, 2026

Policy Changes

Full scope dental benefits will be eliminated for adults 19+ with undocumented immigration status

What Remains Covered

- Emergency dental care for severe pain
- Infections
- Tooth extractions

Who Keeps Full Dental Benefits

- Pregnant individuals
- Postpartum individuals up to 1 year after pregnancy
- Individuals with satisfactory immigration status

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Certain Qualified Noncitizens No Longer Eligible for Full-Scope Medi-Cal – Effective October 1, 2026

Losing Qualified Noncitizen Status

- Refugees
- Asylees
- Individuals paroled into the U.S. for at least one year
- Survivors of domestic violence and trafficking
- Individuals granted withholding of deportation or removal

Remaining Eligible

- Lawful Permanent Residents (LPRs)
- Cuban or Haitian Entrants
- Migrants legally residing in the U.S. and its territories such as citizens from the Marshall Islands, Micronesia or Palau

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2027 & 2028 Medi-Cal Policy Updates

- **January 1, 2027**
  - ACA population ages 19-64
    - Must meet work requirements or prove they are exempt to keep their coverage
    - Required to renew every 6 months
    - Retroactive coverage limited to 1 month of past medical expenses
  - Retroactive coverage period shortened from 3 to 2 months for all other Medi-Cal applicants
- **July 1, 2027**
  - Premium requirements for undocumented adults ages 19-59 receiving full-scope Medi-Cal
- **October 1, 2028**
  - Co-payment requirements for certain health care services for ACA population ages 19-64

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CalFresh Policy Updates

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Disclaimer: The details contained in this presentation are subject to change as official guidance is issued.

Changes to Noncitizen CalFresh Eligibility – Effective April 1, 2026

No Longer Eligible (Under New Federal Rules)

- Asylees
- Refugees
- Parolees
- Battered noncitizens
- Victims of trafficking
- Individuals with deportation or removal withheld

Still Eligible

- Citizens of the United States
- Lawful Permanent Residents (LPRs)

  * Certain LPRs are subject to a five-year waiting period before becoming eligible to CalFresh

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CalFresh Work Requirement Changes – Effective June 1, 2026

Affected Group

Able Bodied Adults Without Dependents (ABAWD) aged 18-64

Key Changes

- Must verify 20+ hours/week of work, an approved training program or volunteering
- A parent of a child younger than 14 years old

Exemptions Removed

- Veterans, former foster youth (aged 18-23) and individuals experiencing homelessness
- People with disabilities remain exempt

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Questions & Answers

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COUNTY OF ORANGE CALIFORNIA

OC Social Services Agency

Our Community, Our Commitment

For more information, please visit: ssa.ocgov.com

SSA Outreach Inbox: ssaoutreach@ssa.ocgov.com

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IMPLEMENTATION PLAN FOR NEW FEDERAL ELIGIBILITY AND ENROLLMENT CHANGES UNDER H.R.1

January 29, 2026

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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Background and Overview

H.R.1 establishes significant new eligibility and enrollment changes to the Medicaid program, including requirements that change eligibility criteria for which individuals are eligible and new parameters for how to enroll in and maintain coverage.[1] These changes will significantly affect California's Medi-Cal program and require proactive outreach with members and community partners in order to support eligible members to enroll in and maintain their coverage. These new changes are expected to impact up to two million Medi-Cal members. This implementation plan outlines the California Department of Health Care Services' (DHCS) approach to mitigating the impact on members and minimizing coverage loss to the greatest extent possible. This document will be updated accordingly throughout the implementation process.

Key Medi-Cal Eligibility Changes Under H.R.1

The following summarizes the new federal changes and their effective dates as required under the federal law.

- **Streamlining Eligibility and Enrollment Final Rules Moratorium *(Effective July 4, 2025)*:** Pauses implementation and enforcement of some provisions in eligibility and enrollment federal rules that were focused on further improving noticing and processing timeframes at application and renewal and streamlining eligibility processes for the Aged and Disabled eligibility groups.[2]
- **Restricting Federal Funding for Certain Qualified Non-Citizens *(Effective October 1, 2026)*:** Changes who counts as a "qualified" immigrant for federally funded Medi-Cal. Individuals who are not considered qualified immigrants for Medi-Cal will transition from federal full-scope Medi-Cal to restricted-scope Medi-Cal as part of the proposed Governor's Budget 2026-2027.
- **Work Reporting Requirements *(Effective January 1, 2027)*:** Requires adult expansion enrollees eligible for federally-funded Medicaid under the Affordable

[1] U.S. House of Representatives. (2025). *H.R.1 — One Big Beautiful Bill Act, 119th Congress (2025).* https://www.congress.gov/bill/119th-congress/house-bill/1

[2] "Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment," 88 Fed. Reg. 65230; and "Medicaid Program; Streamlining Medicaid, CHIP, and BHP Application, Eligibility Determination, Enrollment and Renewal Processes," 89 Fed. Reg 22780.

Care Act, also called the "New Adult Group"[3] to work, study or volunteer at least 80 hours per month unless exempt.

- **Six-Month Renewals *(Effective January 1, 2027)*:** Requires the New Adult Group members to renew Medi-Cal every six months instead of once a year. The renewal period continues to be on an annual basis for all other populations, such as children, pregnant people, older adults, persons with disabilities, and American Indian and Alaska Natives.
- **Reducing Duplicate Enrollment *(Effective January 1, 2027 and October 1, 2029)*:** Codifies the requirement that all states update address information based on information received from other data sources such as the National Change of Address database and returned mail starting in 2027. Effective 2029, the federal government must establish a national database that will identify individuals who may be enrolled in Medicaid in more than one state.
- **Deceased Member Verification *(Effective January 1, 2027)*:** Requires states to verify eligibility against the federal Death Master File on a quarterly basis, or a successor system, to identify individuals who are deceased and should no longer be enrolled in coverage.
- **Retroactive Medi-Cal Timeframes *(Effective January 1, 2027)*:** Reduces retroactive coverage from three months to one month for New Adult Group members and two months for all other Medi-Cal members.[4]
- **Cost Sharing for Adults *(Effective October 1, 2028)*:** Requires states to implement copayments for certain New Adult Group members for some services while keeping essential care—like emergency, prenatal, and mental health visits—free.

Anticipated Coverage Loss and Enrollment Impacts

California's Medi-Cal program currently covers roughly 14.7 million individuals (as of June 2025). DHCS anticipates that the new federal provisions will increase administrative workload and heighten the rate of procedural and paperwork discontinuances.

[3] The New Adult Group encompasses adults ages 19 to 64 with incomes below 138% of the federal poverty level (FPL). In 2025, 138% of the FPL for an individual's annual income is $21,597.

[4] The provision that reduces retroactive timeframes is not expected to impact discontinuance levels. However, it may lead individuals to apply for coverage sooner, force people to incur medical bills for treatment before they can apply for Medi-Cal, and there could be an increase in requests for reconsideration or appeals due to the shortened retroactive eligibility period.

Procedural and paperwork discontinuance is the loss of Medi-Cal coverage because the county did not receive complete information to successfully determine a member's eligibility. More frequent renewals and new work reporting requirements under H.R.1 are expected to increase procedural and paperwork discontinuances.

DHCS remains committed to minimizing burdens through innovative strategies that help keep eligible members covered and new members enrolled. DHCS will continue using existing communication strategies, expand automation, and coordinate extensively with stakeholders and community partners to maintain Medi-Cal coverage for impacted members to the maximum extent possible. To prepare for implementation of H.R.1, DHCS developed this Implementation Plan to inform Medi-Cal members, providers, Managed Care Plans (MCPs), counties, community partners, and other valued stakeholders of expected changes. This work is ongoing and DHCS will update this document frequently using information and feedback gathered from our regularly scheduled stakeholder workgroups. DHCS will continue to share updates via the DHCS Coverage Ambassador webinars.

Automated data verification will be critical to maintaining coverage continuity and limiting additional administrative burden. Although California's *ex parte* automatic renewal rate improved considerably over the last few years due to targeted DHCS efforts to improve verification processes and take advantage of federal flexibilities during the unwinding[5] period, *ex parte* rates dropped back to pre-unwinding levels in July 2025 after unwinding-era flexibilities were terminated. Coupled with new H.R.1 mandates, DHCS anticipates a significant increase in manual administrative workload to support members in retaining coverage.

DHCS is working towards maximizing automatic renewals, where possible, and coordinating with other state agencies, the federal government, and third parties to increase the rate of *ex parte*. Members who successfully go through the automated *ex parte* process have no contact with the county to complete their renewals. However, staggered implementation of H.R.1 and new eligibility criteria, such as work and community engagement requirements, may lower *ex parte* rate success.

Counties will need to review cases that fail auto-renewal and contact members for verification. DHCS will continue to identify opportunities to implement best and

[5] The term *"unwinding"* refers to the process by which DHCS returned to normal Medi-Cal operations following the end of the federal COVID-19 Public Health Emergency (PHE). During the PHE, DHCS implemented more than 100 flexibilities under federal and state authorities to sustain access to care. After enactment of the Consolidated Appropriations Act of 2023, DHCS began unwinding these flexibilities as required by the ending of the federal "continuous coverage" requirement on April 1, 2023, while working to maintain coverage and make permanent select improvements to the Medi-Cal program.

emerging practices and improve *ex parte* success through additional data sources, system enhancements, and collaboration with counties and stakeholders.

DHCS recognizes these changes will unavoidably impact members, most notably a termination of health coverage**.** DHCS anticipates that the large volume and increased frequency of renewals and the introduction of work requirements, combined with normal churn of individuals transitioning from Medi-Cal coverage to Covered California, the State marketplace, will result in up to an estimated total of 1.8 million.[6] Because the provisions take effect on a staggered schedule, disenrollments are expected to occur over the total implementation period, with significant spikes expected in months when major provisions go into effect; full implementation is expected by June 2028.

Medi-Cal's Global H.R.1 Implementation Approach

DHCS will reduce the burden of the H.R.1 changes and maximize continuity of coverage for Medi-Cal members by using innovative solutions to streamline requirements wherever possible. To minimize unavoidable impacts, DHCS will center policy decisions on members and implement new provisions in the least disruptive way possible.

The Department will ensure clear and targeted, in-language communication with affected members, use available data sources to reduce the need for member and county action, equip counties with the tools and training they need to simplify the changes for members, coordinate with providers and MCPs to maintain consistent communication, and leverage providers' and MCPs' relationships with members to amplify outreach, awareness and education, and engagement.

Because H.R.1 affects different types of members and phases over multiple dates,[7] DHCS will issue a series of policy letters, provider bulletins, and guidance to ensure that Medi-Cal members, MCPs (medical, dental, and behavioral health), counties, providers, and stakeholders understand the applicable policies and procedures. The Department will also convene stakeholder workgroups, events, and use existing forums to share updates and gather feedback as implementation progresses.

DHCS Guiding Principles

The implementation of H.R.1 necessitates that DHCS adopt strategies to support eligible individuals in enrolling in and maintaining coverage while maintaining program

[6] This number is subject to updates as additional data becomes available on *ex parte* processing and additional verification sources.

[7] See "H.R.1. Provisions" section for a detailed table outlining particular provisions and their effective dates.

integrity. Building on lessons from the state's implementation of Medi-Cal Continuous Coverage Unwinding, DHCS will apply the following key guiding principles.

1. **Automate to Protect Coverage**
   Maximize the use of state, federal, and third-party data sources to confirm eligibility without burdening members and counties. Reduce paperwork, streamline verifications, and safeguard coverage stability, within federal statutory and regulatory parameters.

2. **Communicate with Clarity and Connection**
   Leverage existing and new communication channels and tools to implement outreach and education campaigns in all threshold languages,[8] designed to be culturally relevant, linguistically accurate, and written in plain language to build trust and help members, their families and caregivers understand the changes and what actions are required of them.

3. **Simplify the Renewal Experience**
   Modernize and streamline the Medi-Cal renewal process with clearer, member-friendly forms (first for the New Adult Group, and later for all other members) and with six-month renewal steps that are easier to navigate, reducing confusion and helping members stay covered.

4. **Educate and Train Those Who Serve Medi-Cal Members**
   Deliver comprehensive training on all H.R.1 provisions for county eligibility. Provide clear policy guidance, practical tools, and ongoing technical assistance so counties, plans, and providers can confidently support members and avoid error on member cases. Provide DHCS Coverage Ambassadors with informative webinars, flyers, and communication toolkits to stay informed and help Medi-Cal members navigate these changes to stay covered.

5. **Provide Timely and Transparent Communication to Members**
   Share information on H.R.1 changes early on and via multiple channels (mail, text, outbound phone calls, etc.) so members can build awareness, anticipate changes to their coverage, and have ample preparation time to meet new requirements.

[8] English, Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Mien, Punjabi, Russian, Spanish, Tagalog, Thai, Ukrainian, and Vietnamese.

H.R.1 Provisions

Each subsection below summarizes key provisions of H.R.1 that impact Medi-Cal operations, including each provision's effective date, a brief description of the corresponding federal requirement, implementation considerations, federal guidance provided to date, and DHCS operational impacts. These provisions collectively reshape state responsibilities related to eligibility, coverage continuity, data reporting, and program integrity.

Streamlining Eligibility Final Rule Moratoriums (Effective July 4, 2025)

Federal Requirement: Effective immediately (July 4, 2025) through September 30, 2034, Sections 71101 and 71102 of H.R.1 pause the implementation and enforcement of certain parts of two final rules issued by the Centers for Medicare & Medicaid Services (CMS):

- Streamlining Medicaid; Medicare Savings Program Eligibility Determination and Enrollment, released on September 21, 2023, and
- Medicaid Program; Streamlining the Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes, released on April 2, 2024.

DHCS Action: To implement the pause of these rules, DHCS has suspended the implementation of applicable provisions from the 2023 and 2024 CMS final rules.[9] DHCS will maintain the following provisions, currently in effect:

- California will continue to automatically enroll Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipients who qualify for Medicare into the Qualified Medicare Beneficiary (QMB) program. This process reflects California's status as a Medicare buy-in state and is detailed in the All County Welfare Directors Letter (ACWDL) 24-20 and Medi-Cal Eligibility Division Information Letter (MEDIL) 25-01.

[9] ACWDL 25-07, "STREAMLINING MEDICARE SAVINGS PROGRAMS (MSPs) ELIGIBILITY DETERMINATIONS USING LOW-INCOME SUBSIDY (LIS) LEADS DATA AND ALIGNING THE DEFINITION OF FAMILY SIZE FOR MSPs" is now listed as obsolete. For more information on ACWDL status, please refer to DHCS' website here: https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Pages/ACWDLbyyear.aspx

- DHCS will continue to remove the requirement that an individual apply for other benefits (like unemployment benefits) before qualifying for Medi-Cal, as outlined in ACWDL 24-19.

Amended Eligibility for Federally-Funded Medicaid (Effective October 1, 2026)

Federal Requirement: Effective October 1, 2026, Section 71109 of H.R.1 narrows noncitizen eligibility for federally-funded Medicaid. This change means many lawfully residing immigrants who are currently eligible for federally-funded Medi-Cal as qualified non-citizens will no longer be eligible for federally funded Medi-Cal coverage.

Under the proposed Governor's Budget 2026-2027, the following groups will be ineligible for federally-funded Medi-Cal and be eligible for restricted-scope Medi-Cal per:

- Refugees.
- Asylees.
- Amerasian Immigrants.
- Individuals granted withholding of deportation or removal.
- Conditional entrants granted before April 1980.
- Individuals paroled into the United States for one year or more.
- Battered non-citizens, or the parent or child of a battered non-citizen.
- Victims of human trafficking.
- Individuals granted humanitarian parole, such as certain Afghans who aided U.S. operations in Afghanistan or people fleeing violence in the Ukrainian war.

This change will impact the individuals in the groups above, who have an immigration status removed from the qualified non-citizen definition for federally-funded Medicaid, who are lawfully present, aged 21 or older, and not pregnant. In addition, as of January 1, 2026, Covered California will be required to use this same qualified non-citizen definition, making individuals with income below 100% of the federal poverty level (FPL) who are currently eligible for advanced premium tax credits (APTC) to help pay for qualified health plans ineligible for those credits. The new qualified non-citizen definition will also apply to individuals with income at or above 100% of the FPL beginning January 1, 2027. Similarly, as of July 4, 2025, Medicare eligibility is restricted to U.S. citizens, legal permanent residents, certain Cuban and Haitian entrants, and individuals residing in the U.S. under COFA. Current Medicare enrollees with other immigration statuses are ineligible for Medicare and coverage will be terminated in

January 2027. Some current dually eligible individuals who are noncitizens will see both Medicare and federally funded Medicaid coverage loss.

Similarly, beginning July 4, 2025, this new qualified non-citizen definition will also make current Medicare enrollees in these categories ineligible for Medicare coverage. The new qualified non-citizen definition may also cause those who are dually eligible for Medicare and Medi-Cal to lose coverage in both programs.

Only the following groups will meet the Satisfactory Immigration Status (SIS) requirement for federally funded Medi-Cal:

- Lawful Permanent Residents (LPRs), who are subject to and have met their five-year bar;
- Cuban and Haitian Entrants; and
- Migrants legally residing in the United States and its territories under the Compact of Free Association (COFA) who are citizens of the Marshall Islands, Micronesia, or Palau.

U.S. citizens, lawfully present children under the age of 21 and lawfully present pregnant individuals covered under the Children's Health Insurance Program Reauthorization Act (CHIPRA), CHIPRA 214 option, will continue to qualify for federally-funded Medi-Cal.

DHCS Action: To implement this provision, DHCS will update its eligibility determination systems to reclassify current and newly applying members (belonging to the newly excluded immigration status groups above) into restricted-scope Medi-Cal.

DHCS will issue additional guidance through an ACWDL and conduct follow-up training through county engagement efforts to support this implementation.

Work Reporting Requirements (Effective January 1, 2027)

Federal Requirement: Effective January 1, 2027, Section 71119 of H.R.1 establishes new federal work and community engagement requirements for the New Adult Group. Impacted applicants will be required to demonstrate compliance with or exemption from[10] the new requirement in the one month prior to the month in which they apply. For continued coverage, impacted members will need to demonstrate compliance or exemption in any one month during their new six-month renewal period (described below).

[10] DHCS is seeking guidance from CMS on the timing for exemptions at application.

Under the new requirement, adults aged 19-64 enrolled in the Affordable Care Act New Adult Group must complete one or more qualifying activities:

- Have a monthly income at least 80 times the federal hourly minimum wage ($580);
- Seasonal employment averaging at least at least 80 times the federal hourly minimum wage ($580) over the preceding six months;
- Employment of 80 hours per month;
- Community service of 80 hours per month;
- Enroll at least half-time in an educational program;
- Participation in a work program of 80 hours per month; or
- Combination of employment, community service, work program, and/or education of 80 hours per month.

Individuals who meet the following criteria do not need to demonstrate compliance with work requirement's qualifying activities and are not subject to six-month renewals:

- Enrolled in one of the following Medi-Cal eligibility groups:
  - Pregnant or up to 12 months postpartum
  - Foster youth
  - Former foster care youth under age 26
  - Aged, Blind, or Disabled people (including individuals who receive SSI)
  - Children under age 19
- American Indian/Alaska Natives

Individuals who meet one of the following reasons for exemption do not have to demonstrate compliance with work requirement's qualifying activities at application and during their six-month renewal period:

- Parents/guardians/caregivers of a dependent child age 13 and younger
- Parents/guardian/caregivers of a disabled individual
- Veterans with a disability rating of total
- Incarcerated or recently released from a correctional facility within the past 90 days
- Entitled to Medicare Part A or enrolled in Part B
- Meeting TANF or SNAP (CalFresh) work requirements
- Participating in drug/alcohol treatment programs
- Medically frail, per the statute, this includes individuals (1) with a substance-use disorder (SUD); (2) with a disabling mental disorder; (3) with a physical, intellectual or developmental disability that significantly impairs their ability to

perform one or more activities of daily living; (4) with a serious or complex medical condition; or (5) who are blind or disabled (as defined in section 1614 of the Social Security Act)).[11]

DHCS will also implement optional short-term hardship exemptions and automatically apply them as applicable to applicants and members to the maximum extent possible. Short-term hardship exemptions include:

- **Emergency declaration:** If a person lives in a county or local jurisdiction where, during the month that they were subject to the work requirement, there was an emergency or disaster declared by the President, DHCS will automatically provide a short-term hardship exemption from the work requirements.
- **Unemployment rate:** If a person lives in a county or local jurisdiction (not yet defined by CMS) that has an unemployment rate of 8% or 1.5 times the national unemployment rate (whichever is lower) during a month that they were subject to the work requirement, DHCS will automatically provide a short-term hardship exemption.
- **Inpatient care:** If, during a month when a person would have been required to meet the work requirement, the person received inpatient care at a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services or such other services of similar acuity (including outpatient care relating to other specified services), the individual may request a short-term hardship exemption from DHCS.
- **Travel for care:** If, during a month when a person would have been required to meet the work requirement, the person or their dependent must travel outside of their community for an extended period of time to receive medical services to treat a serious or complex medical condition, the individual may request a short-term hardship exemption from DHCS.

DHCS Action: DHCS currently does not require any Medi-Cal members to participate in work or community engagement activities to maintain eligibility. Beginning on January 1, 2027, under this new policy, eligible individuals must be found either in compliance with or exempt from the new work reporting requirements. This new provision will apply to all applications submitted on or after January 1, 2027. DHCS seeks to implement this new requirement for current Medi-Cal members as their coverage comes up for renewal in 2027.

[11] DHCS will provide additional information on medically frail criteria at a later date.

To implement this provision, DHCS will revise eligibility policies and procedures—including the *ex parte* review process—to incorporate compliance and exemption verification processes. DHCS will establish a streamlined process that allows affected members to easily report their work activities or exemptions online and through other commonly used modalities. The Department will issue policy guidance and resources for counties and update systems to maximize automation. As part of the Governor's January Proposed Budget 2026-27, DHCS is requesting funding to launch extensive communication and outreach campaigns, inclusive of paid media, to educate Medi-Cal members and applicants about the new eligibility requirements.

To maintain parity across all New Adult Group populations receiving full-scope Medi-Cal benefits, DHCS plans to implement work reporting requirements for all New Adult Group enrollees (currently categorized under the M1 aid code). This includes unsatisfactory immigration status (UIS) members who qualify for the expansion New Adult Group coverage but for their unsatisfactory immigration status and are thus enrolled in the M1 aid code and covered through state funding. While many UIS individuals may be already compliant with qualifying activities, DHCS expects that verifying such compliance with existing income data sources may be challenging. Operationally, while DHCS intends to include expansion New Adult Group UIS members in work reporting requirements verification flows to determine exemption or compliance status, DHCS plans to develop a verification process for UIS individuals that takes into account expected data verification limitations. If DHCS is unable to verify compliance or exemption from available data sources, DHCS will rely on other available information provided by the individual, similar to existing processes used today to verify income-based eligibility for UIS members.

Six-Month Renewals (Effective January 1, 2027)

Federal Requirement: Effective January 1, 2027, Section 71107 of H.R.1 requires states to increase eligibility renewal frequency for the New Adult Group.

DHCS Action: DHCS currently conducts Medi-Cal eligibility renewals annually for all members. This provision increases the renewal frequency for the New Adult Group from every twelve months to every six months. American Indian and Alaska Native members are exempt from this requirement and will continue to renew annually. Individuals in Medi-Cal coverage groups outside of the New Adult Group such as children, pregnant and postpartum individuals, foster care youth and former foster care youth under age 26, Disabled or Aged members will also continue on an annual renewal schedule.

To implement this provision, DHCS will apply existing policies and procedures surrounding annual renewals—including the *ex parte* review of existing information on file—to the six-month cycle. It is anticipated that six-month renewals along with the new work requirements will increase procedural and paperwork terminations. To mitigate increased procedural and paperwork terminations, the *ex parte* process will include automated verification processes to the maximum extent possible to support verification of compliance with or exemption from work requirements. DHCS will also introduce a streamlined renewal form and online platform for the affected population that cannot be automatically renewed using available data sources, issue policy guidance and resources for counties, coordinate system updates and enhancements, and explore additional opportunities for streamlining the renewal process for affected members.

Reducing Duplicate Enrollment Under the Medicaid and CHIP Programs (Effective January 1, 2027)

Federal Requirement: Effective no later than January 1, 2027, Section 71103 of H.R.1 requires counties to establish a process that regularly checks and updates Medi-Cal members' addresses using trusted sources identified in H.R.1. These sources include:

- The USPS National Change of Address (NCOA) database;
- Mail returned to the county by USPS with a forwarding address; and
- Updated address information reported from Medi-Cal MCPs.

This provision was previously included in the 2024 CMS Streamlining Eligibility Final Rule.[12] Although H.R.1 placed an implementation and enforcement moratorium on certain provisions in that rule, it maintains the requirement to have a process in place to regularly check and update Medi-Cal members' addresses using trusted sources.

By October 1, 2029, the federal HHS will develop and operate a national system to detect and prevent duplicate Medi-Cal enrollment across state lines. Counties will be required to transmit, on a monthly basis and at every renewal, certain data, such as a Social Security number (SSN), to the new federal database that will be developed in order to identify multi-state enrollment. Counties will then be responsible for acting on the information received.

DHCS Action: To implement the contact information provision, DHCS will continue to partner with counties and the California Statewide Automated Welfare System

[12] The effective date for this policy under the final rule was October 2025. H.R.1 provides states with an additional 14 months to become compliant.

(CalSAWS) to identify and execute system improvements that automate address updates and enhance efficiency. This includes efforts to integrate the National Change of Address (NCOA) database to automatically update member contact information.

DHCS is also exploring opportunities to automate updated member contact information received from other trusted sources such as Managed Care Plans to support accurate and timely updates to the member's record.

To implement the multi-state enrollment provision, DHCS will collaborate closely with CMS. Once HHS releases further guidance, DHCS will issue instructions through ACWDLs and deliver additional training to counties to ensure consistent implementation.

Deceased Member Verification (Effective January 1, 2027)

Federal Requirement: Effective January 1, 2027, Section 71104 of H.R.1 requires counties to review the Social Security Administration's (SSA) Death Master File (DMF) at least quarterly to identify Medi-Cal members who have died. When a member appears in the DMF, counties must treat that information as confirmation of the member's death and promptly take appropriate action to update their Medi-Cal record.

DHCS Action: DHCS currently reviews death data every quarter using an external data source. To implement this provision, DHCS may be required to use SSA's DMF instead of, or in addition to, other sources. DHCS will provide more information once CMS issues additional guidance and, if required, issue instructions in a future ACWDL.

Reduced Retroactive Medi-Cal Coverage Periods (Effective January 1, 2027)

Federal Requirement: Effective January 1, 2027, Section 71112 of H.R.1 reduces the retroactive eligibility period for Medi-Cal. Under current policy, applicants can receive up to three months of retroactive eligibility if they meet all other program requirements during that period. Retroactive coverage ensures that individuals applying for Medi-Cal who have medical needs prior to their application can have those costs covered.

This change shortens the timeframe in which applicants can receive Medi-Cal coverage for past medical expenses, shifting from a uniform three-month period to shorter, group-specific limits.

Under the new policy:

- For individuals enrolled in the New Adult Group, retroactive coverage will be limited to one month prior to the application month.

- For all other individuals (including children, families, seniors, and persons with disabilities), retroactive coverage will be limited to two months prior to the application month.

Cost Sharing for New Adult Group (Effective October 1, 2028)

Federal Requirement: Effective October 1, 2028, Section 71120 of H.R.1 creates new cost-sharing requirements for certain adults enrolled in the New Adult Group with incomes above 100 percent of the federal poverty level. Under this provision, states must charge co-payments greater than zero dollars but not more than thirty-five dollars per service, as determined by the state. Cost-sharing cannot be required on certain important services including, but not limited to:

- Certain emergency services;
- Primary care;
- Prenatal care;
- Family planning;
- Pediatric care;
- Federally Qualified Health Center (FQHC) and Rural Health Clinic; and
- Behavioral health.

Cost sharing is subject to an aggregate limit of 5% of family income.

DHCS Action: Prior to July 1, 2022 when cost-sharing for members was eliminated, Medi-Cal imposed nominal copayments (generally $1) for most covered services. To ensure this policy did not create access barriers to services for members, providers were prohibited from denying services for lack of payment and provider payments were not reduced by the amount of expected copays. To implement this provision, DHCS will similarly establish nominal copayment amounts and develop and deploy targeted communication and outreach campaigns to educate Medi-Cal members, providers, and hospitals about the new cost-sharing requirements. DHCS will clarify what services are subject to copayments, that services cannot be denied for lack of payment, and ensure members understand that essential services remain exempt.

Stakeholder and Member Communication

Stakeholder Engagement: DHCS collaborates with a wide range of stakeholders—including counties, MCPs, advocates, providers, and community-based organizations—to prepare for and implement changes in Medi-Cal requirements. Stakeholder experience, expertise and feedback will be critical in:

- Developing policy guidance on business activities to implement the provisions of H.R.1.
- Designing and delivering trainings, flowcharts, and other tools to support county operational planning and staff development.
- Enhancing existing policies and business processes to increase efficiencies in case processing and to reduce barriers to continued coverage. This includes updating policy guidance, exploring other federal eligibility flexibilities, and incorporating Medi-Cal retention strategies developed by DHCS, stakeholders, and CMS.
- Identifying innovative solutions to obtain updated member contact information, including utilizing MCPs to reach out to members and providing counties with reported address changes.
- Providing messaging and materials to support member outreach and education efforts.

Through a collaborative and multi-phased approach, DHCS and stakeholders will ensure that Medi-Cal members are properly equipped with the information and support they need to adapt to the upcoming changes while helping members maintain access to care.

Listed below are the stakeholder engagement channels DHCS anticipates using to elicit stakeholder feedback and share important information related to H.R.1.

Stakeholder Engagement Channels

Communication Channel	Example Engagements
Public Forums	» All Comers Webinar » DHCS Stakeholder Update
Workgroups	» DHCS/County H.R.1 Workgroup » Managed Care Plan H.R.1 Workgroup » County Welfare Directors Association (CWDA) Self Sufficiency Committee » DHCS/Community H.R.1 Stakeholder Workgroup[13] » DHCS Medi-Cal Consumer-Focused Stakeholder Workgroup » DHCS Medi-Cal Member Advisory Committee » H.R.1 Medi-Cal Member Focus Groups *(planning in progress)* » DHCS Stakeholder Advisory Committee (SAC) & DHCS Behavioral Health Stakeholder Advisory Committee (BH-SAC) » DHCS Coverage Ambassadors » Medi-Cal Member Advisory Committee » Medi-Cal Voices and Vision Council
Guidance	» ACWDLs » MEDILs » APLs » Behavioral Health Information Notices (BHINs)
Formal Notices	» Member Outreach Notices » Medi-Cal Renewal Notices

[13] Workgroup members include: California Advocates for Nursing Home Reform, California Department of Social Services, California Health Care Foundation, California Immigrant Policy Center, California Pan-Ethnic Health Network, California PACE Association, Children Now, Coalition of California Welfare Rights Organizations, Community Clinic Association of Los Angeles County, County Behavioral Health Directors Association, Community Legal Aid SoCal, Corporation for Supportive Housing, County Welfare Directors Association, Disability Rights California, Disability Rights Education and Defense Fund, Family Voices of California, Golden Policy Consulting, Health Access California, Homebase, Justice in Aging, Keck School of Medicine of USC, Legal Aid Society of San Mateo County, National Health Law Program (NHeLP), National Immigration Law Center, Neighborhood Legal Services of Los Angeles County, Parallon, PRC San Francisco, Public Law Center, SEIU California, The Children's Partnership, UDW, and Western Center on Law & Poverty.

Anticipated DHCS Stakeholder Engagement Activities Related to H.R.1

See above for Communication Channels DHCS will utilize to execute these stakeholder engagement activities.

H.R.1 Provision	Impacted Partners	Topics to Discuss	Timeline for Engagement
Restricting Federal Funding for Certain Qualified Non-Citizens (QNC) *Effective Date:* October 1, 2026	» Counties » MCPs » Eligibility systems[14] » Members » Community Partners/Advocates » Health Care Providers » CoveredCA	**Phase 1: Awareness and Preparation** » Meet with impacted partners for input on approaches for amended rules on who qualifies for federally-funded Medi-Cal coverage **Phase 2: Support and Action** » Training and technical assistance (TA) to counties, MCPs, and CoveredCA to support implementation » Education to immigrant populations to improve understanding and awareness of upcoming changes	Jan 2026 – July 2027
Work Reporting Requirements *Effective Date:* January 1, 2027	» Counties » MCPs » Eligibility systems » Members » Community Partners/Advocates	**Phase 1: Awareness and Preparation** » Meet with impacted partners to solicit input on ways to implement, and provide effective outreach for, new work reporting requirements and implications	October 2025 – January 2027

[14] These include the California Statewide Automated Welfare System (CalSAWS) and the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) that collect and manage eligibility information and support eligibility determinations for individuals applying for and renewing coverage for programs such as CalFresh (CalSAWS) and Medi-Cal (CalHEERS).

H.R.1 Provision	Impacted Partners	Topics to Discuss	Timeline for Engagement
	» Health Care Providers » CoveredCA	for: eligibility determinations at application and renewal, notices, training materials, education, and outreach » Provide opportunity for input on process design for verifying compliance with work reporting requirements and exemptions. **Phase 2: Support and Action** » Distribute ongoing outreach communication and notices to all impacted partners and members in advance of renewal to promote awareness » Collaborate with impacted partners on guidance, training, updating systems, and TA to counties, CalSAWS, MCPs, and CoveredCA to support implementation	
Six-Month Renewals	» Counties » MCPs » Eligibility systems	**Phase 1: Awareness and Preparation** » Provide education to all impacted partners to promote awareness and	October 2025 – January 2027

H.R.1 Provision	Impacted Partners	Topics to Discuss	Timeline for Engagement
Effective Date: January 1, 2027	» Members » Community Partners/Advocates » Health Care Providers » Covered CA	understanding of process/timing for more frequent renewals » Solicit input from implementation partners on design for streamlining renewals and conducting *ex parte* to the maximum extent possible **Phase 2: Support and Action** » Collaborate with impacted partners on the development and provision of guidance, training, updating systems, and TA to counties, MCPs, and CoveredCA on implementing more frequent renewals	
Reducing Duplicate Enrollment Under Medicaid/CHIP *Effective Date:* January 1, 2027 and October 1, 2029	» Counties » MCPs » Eligibility systems » Members » Community Partners/Advocates » Health Care Providers	**Phase 1: Awareness and Preparation** » Provide overview on process for regularly checking and updating members' addresses to all impacted partners; solicit input from impacted partners to inform development of formal process **Phase 2: Support and Action**	January 2026 – October 2029

H.R.1 Provision	Impacted Partners	Topics to Discuss	Timeline for Engagement
		» Training and TA to counties to support implementation of requirement to share information with new HHS national system starting 10/1/29	
Deceased Member Verification *Effective Date:* January 1, 2027	» Counties » MCPs » Eligibility systems » Community Partners/Advocates	**Phase 1: Awareness and Preparation** » Engage with counties on process for identifying deceased members using the SSA DMF » Collaborate with impacted partners on ideas to address SSA DMF errors. **Phase 2: Support and Action** » Provide targeted TA, as needed	June 2026 – January 2027
Retroactive Medi-Cal Reduced Retroactive Eligibility *Effective Date:* January 1, 2027	» Counties » MCPs » Eligibility systems » Members » Community Partners/Advocates » Health Care Providers	**Phase 1: Awareness and Preparation** » Provide education to all impacted partners on new reduced retroactive eligibility period and implications for coverage » Collaborate with impacted partners on how to communicate out and implement changes **Phase 2: Support and Action**	June 2026 – January 2027

H.R.1 Provision	Impacted Partners	Topics to Discuss	Timeline for Engagement
		» Provide guidance, training and TA to counties and MCPs to support implementation	
Cost Sharing for New Adult Group *Effective Date:* October 1, 2028	» MCPs » Members » Community Partners/Advocates » Providers	**Phase 1: Awareness and Preparation** » Provide education to Impacted Partners on new cost-sharing requirements » Collaborate with impacted partners on how to communicate out and implement new requirements **Phase 2: Support and Action** » Provide training and TA to MCPs and Providers to support implementation	January 2028 – October 2028

Member Communication and Outreach

DHCS will lead a coordinated communication and outreach strategy to ensure stakeholders, including counties, MCPs, community partners, and Medi-Cal members, have the information they need as the H.R.1 provisions take effect. The Department's goal is to deliver clear, consistent, and culturally responsive messaging that helps members understand changes, identify actions they may need to take, know which communications are from DHCS to avoid scams, and find the support available to them consistent with the Guiding Principles described above.

DHCS will rely on our stakeholders to be trusted messengers and help share information with Medi-Cal members. DHCS will also leverage existing channels to reach diverse communities, including mailed notices, social media, targeted texting and earned media.[15]

DHCS will produce plain-language materials and toolkits, translated into all 19 Medi-Cal languages, that include frequently asked questions (FAQs), informational flyers, and templates to help ensure members receive accurate and consistent information. The Department will regularly update resources on the changes that directly impact Medi-Cal members and make them available through the DHCS websites and the Coverage Ambassador network.

Phased Approach: To ensure members receive timely and useful information, DHCS will implement a two-phased communications and outreach approach:

- **Phase 1: Awareness and Preparation:** DHCS will raise awareness of upcoming changes and prepare members for specific actions they must take to maintain their Medi-Cal coverage ahead of programmatic changes. Stakeholders will leverage DHCS materials for outreach and education efforts (e.g., earned media, social media, toolkits).
- **Phase 2: Support and Action:** As the implementation dates get closer, DHCS will shift its communication to focus on the specific actions members must take, such as responding to notices or completing renewal packets. Messaging will reinforce this through direct outreach, reminders, and targeted assistance to help members retain coverage (e.g., public notices, toolkits).

[15] Over 6,000 Coverage Ambassadors currently operate across the state to help individuals find, better understand, and maintain their health coverage.

Communications Channels

DHCS will deploy its multi-channel communications strategy using:

- **Toolkits:** Messaging guides, flyers, and FAQs that align with public notices. They will be posted on the DHCS website in all 19 Medi-Cal threshold languages and disseminated to counties, community partners, Coverage Ambassadors, and Managed Care Plans.
- **Public Notices:** Formal notices and FAQs will be aligned with toolkit messaging and mailed directly to affected members in their preferred language. These will be posted online and shared with counties, MCPs, and Behavioral Health Plans (BHPs) through APLs, MEDILs, and BHINs.
- **Earned Media:** DHCS will pitch stories to reporters and respond to media inquiries, recognizing that H.R.1 changes are of high interest to the press. Ethnic media partners will play a critical role in reaching culturally and linguistically diverse communities.
- **Social Media**: DHCS will use its social platforms to share updates, reminders, and educational content. There are separate platforms for DHCS stakeholders and Medi-Cal members.
- **Texting:** A limited, targeted texting strategy to raise awareness about the new work reporting requirements will begin in early 2026.
- **DHCS Coverage Ambassadors:** With a network of more than 6,000 partners statewide, Coverage Ambassadors include counties, MCPs, advocates, providers, schools, and community organizations. DHCS will rely on ambassadors to distribute resources and messaging at the local level. Ambassadors receive updates via email, webinars, and a web portal, with webinars also serving as a feedback loop to improve communications.

Timeline of Activities

Key Change	Awareness Materials	Awareness Dates	Support and Action Materials	Support and Action Dates
Restricting Federal Funding for Certain Qualified	» Toolkit » Coverage Ambassadors Webinar	January-March 2026	» Public Notice » Social Media	July-October 2026

Key Change	Awareness Materials	Awareness Dates	Support and Action Materials	Support and Action Dates
Non-Citizens *(October 1, 2026):*	» Earned Media			
Six-Month Renewals *(January 1, 2027)*	» Toolkit » Coverage Ambassadors Webinar » Earned Media	January-September 2026	» Public Notice » Social Media	October-January 2027
Cost Sharing for Adults *(October 1, 2028)*	» Toolkit » Coverage Ambassadors Webinar » Earned Media	May-June 2028	» Public Notice » Social Media	July-October 2028

DHCS is exploring opportunities with philanthropic organizations to expand its communications and outreach efforts in support of H.R.1 implementation. This includes increasing multilingual text messaging to remind members about key changes such as six-month renewals and potentially other changes. DHCS is also considering broader distribution of printed materials to clinics and community partners, expanded use of paid media, and placing trained navigators in clinics to assist members directly. DHCS will work with stakeholders to identify additional ways to strategically use this texting strategy.

Readiness

County Readiness

Local county offices play a critical role in administering Medi-Cal eligibility and managing Medi-Cal cases on behalf of DHCS. The provisions in H.R.1 will significantly increase county workloads through:

- Work requirements;
- More frequent renewals that require manual verification and direct contact with members by the county;
- Increased phone and foot traffic at county call centers and local offices; and
- Increased churn in members gaining and losing coverage.

Recognizing the expanded workload—in addition to counties' ongoing responsibilities for application adjudication and ongoing case management—DHCS will continue to work closely with the County Welfare Directors' Association and counties to assess the additional impact through the state budget process.

Under DHCS oversight, California's 58 local county offices determine Medi-Cal eligibility, distribute notices, manage active Medi-Cal cases, and renew each member's eligibility. DHCS issues guidance to counties to perform these activities.

Preparing counties for H.R.1 provisions is vital to the success of implementation. DHCS will provide counties with guidance, resources, and technical support—detailed in the following sections—to ensure counties can efficiently and effectively administer the Medi-Cal program.

Regular Policy Guidance: DHCS will issue ongoing policy guidance on H.R.1 provisions to counties (see "Resources" section, which DHCS will update as new information becomes available). DHCS will continuously issue written policy guidance that clarifies existing policies, updates processes and system changes, and provides operational direction for counties throughout implementation.

This written policy guidance will also serve as the foundation for DHCS' targeted training courses for counties available statewide. Provisions expected to require published policy guidance include:

- Amended Federal Funding for Certain Immigrants
- Work Reporting Requirements
- Six-Month Renewals
- Retroactive Medi-Cal Reduced Timeframes
- Reducing Duplicate Enrollment Under the Medicaid and CHIP Programs
- Deceased Member Verification

County Support Webinars: In addition to the targeted county workgroups described in the *"Stakeholder and Member Communication"* section, DHCS facilitates monthly policy support webinars with counties. These webinars provide counties with updates on policy, guidance, targeted training topics, system training and support, and other topics

as identified by DHCS or county staff. The webinars are recorded so counties may reinforce and distribute them among their staff.

Tools and Resources: DHCS will provide counties with additional tools and resources to support H.R.1 implementation. DHCS and counties will identify needed materials through targeted county workgroups and policy support webinars.

Tools and resources include, but are not limited to, checklists, quick-reference tools, workflows, visuals, training materials, and other materials as identified. DHCS will provide more specific information on the tools and resources for each provision as they become available.

Statewide H.R.1 Provision Training: DHCS will conduct statewide county trainings on H.R.1 provisions through webinars and, as resources allow, in-person sessions. These trainings will cover both new requirements and refresher topics to existing policies affected by the provisions. DHCS will announce final training topics and dates once finalized. A high-level overview of a tentative schedule can be found below. The webinars are recorded so counties may reinforce and distribute them among their staff.

Training Schedule

Training	Training Topic	Date
Immigration-Related Provisions	Immigration-related changes in H.R.1 and state budget changes to immigrant population policies.	Summer 2026
Work Reporting Requirements	Work Reporting Requirements and applicable exemptions provision policy implementation	TBD 2026 (to be updated by DHCS in next iteration of Implementation Plan)
Six-Month Renewals	Six-Month Renewals provision policy implementation	TBD 2026 (to be updated by DHCS in next iteration of Implementation Plan)

Training	Training Topic	Date
Preventing Duplicate Enrollment Provision: Updated Member Contact Using Trusted Sources	Automation of updating member contact information using trusted data sources and ensuring members are not enrolled in multiple state Medicaid programs	TBD 2026 (to be updated by DHCS in next iteration of Implementation Plan)
Retroactive Medi-Cal Reduced Timeframes	New retroactive Medi-Cal timeframes	TBD 2026 (to be updated by DHCS in next iteration of Implementation Plan)
Preventing Duplicate Enrollment Provision: New HHS System	What is required of counties to maintain compliance with federal requirements for the new HHS national system	TBD 2028

Eligibility and System Readiness

The CalSAWS and California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) are updating their systems to align with the new federal provisions under H.R.1. The updates focus on policy alignment, system development, testing and validation, and operational preparedness.

CalSAWS, CalHEERS, and DHCS are following a phased implementation schedule that aligns with federal deadlines. DHCS continues to collaborate closely with CalSAWS and CalHEERS to review and test functionality, implement required updates, and ensure seamless integration with other state and federal systems. This includes integrations to support *ex parte* verification of member compliance with or exemption from work reporting requirements by leveraging data sources from other systems/entities that are either currently in use or being explored for potential use. The tables below share examples of these data sources and how they may be used to support eligibility verification for work reporting requirements.

CalSAWS and CalHEERS will collaborate with stakeholders to review, test, and inform member-facing enhancements to BenefitsCal and the CalHEERS portal. This engagement

will help ensure that the digital experience is intuitive, streamlined, and supports successful navigation and completion of key actions. Stakeholders will also contribute input on non-member-facing system modifications through established workgroups and focused discussions.

Examples of Data Sources For Verifying Compliance with Work Reporting Requirements (Income or Hours)

Compliance/Exemption Category	Potential Data Source	Status
Income of at least $580/month and/or 80 hours of work	State Quarterly Wage Data (EDD) and IRS Data	Currently in use
	Equifax Work Number (provides timely income data and hours of work)	DHCS executed a one-year contract to access database
	Gig Economy Data	California is assessing several options, including TRUV
	CalFresh, CalWORKs, GA/GR, and other income information in CalSAWS	Currently in use
Veteran with disability rated as total	Veteran Service History and Eligibility Application Programming Interface (API)	DHCS is exploring potential data sources

Examples of DHCS Data Sources for Identifying Eligibility Group and Medical Frailty Exemptions for Work Reporting Requirements

Exemption Category	Potential Data Source	Status
» Child under 19 » Pregnant or postpartum » Foster youth and former foster care youth » Aged/disabled » Parents/caretaker relatives » Inmate of a public institution or recently released from incarceration	Medi-Cal Eligibility Aid Codes	System to be configured to exempt individuals from work reporting requirements
Medically Frail Exemption Category	All Claims and Encounters (e.g., submitted through PACES, CA-Medicaid Management Information System (MMIS) and Medi-Cal Rx)	» DHCS will exempt individuals who are eligible for certain programs (e.g., HCBS, HCBA waiver, MCWP formerly AIDS Waiver, ALW, CBAS, CCS, PACE, Enhanced Care Management, Community Supports) to extent program eligibility aligns with Medically Frail criteria » In addition, DHCS is evaluating which International Classification of Diseases (ICD)-10 and Current Procedural Terminology (CPT) Codes could be used to identify diagnosis and utilization data to establish medical

Exemption Category	Potential Data Source	Status
		frailty, alcohol/drug treatment, pregnancy, and more » DHCS is also exploring other potential data sources (e.g., MCP care management systems) for timely sources of exemption data
	Short Doyle System	System to be configured to pull in data for identifying exemption

Examples of Cross-State Data Sources for Identifying Compliance/Exemptions for Work Reporting Requirements

Compliance/Exemption Category	Data System	Status
Compliance with CalWORKs (TANF)/CalFresh (SNAP) Work Requirements	California Statewide Automated Welfare Systems (CalSAWS)	System to be configured to pull in DSS data for identifying exemption
Part-Time Education	California Student Aid Commission (CSAC) and University of California (UC) data/ California State University (CSU) data CA Department of Education (DOE)	DHCS is exploring potential for data matching
80 hours of work program participation	Department of Rehabilitation or other state agencies	DHCS is exploring potential for data matching

Implementation Partner Role

Role of Providers

Provider engagement for H.R.1 aims to keep health care providers informed and prepared during the transition. DHCS will issue bulletins, policy guidance, technical assistance and trainings, and web updates to outline program changes and explain updated workflows and system processes. These efforts will help providers comply with federal requirements and continue delivering consistent, quality care to Medi-Cal members. As trusted advisors to their patients, these efforts will also ensure providers have up-to-date information on program changes, so they are prepared to assist patients who may need support gathering documentation for exemptions from work requirements.

Planned engagement with providers will include working with specific provider types that may be able to support identification of members exempted from H.R.1 work reporting requirements. These include, but are not limited to, providers who specialize in behavioral health treatment, inpatient care, and who work with individuals with intellectual and developmental disabilities and recently incarcerated members. Examples of documentation that these providers could produce to support a medically-based exemption, if documentation is required by CMS, include, but are not limited to, treatment records for a serious or chronic medical or mental health condition, substance use disorder, or a recent inpatient stay. Additionally, DHCS is exploring the potential role of Enhanced Care Management (ECM) providers in conducting outreach to and supporting members with navigating new work reporting requirements and increased eligibility renewals.

Role of Medi-Cal MCPs

MCPs play a critical role in helping members understand and navigate eligibility and enrollment requirements. In previous efforts, such as the COVID-19 unwinding, MCPs served as trusted messengers, providing timely information and supporting members through the renewal process to help maintain continuous coverage.

For H.R.1 implementation, DHCS will again engage MCPs as key communication partners. The Department will provide clear messaging and direction through All Plan Letters, including how MCPs can leverage DHCS-approved outreach materials. Many MCP representatives are also enrolled as DHCS Coverage Ambassadors, further

extending their reach and alignment with statewide messaging. To do this, MCPs may use several strategies:

- Obtain and update member contact information (through communication with the local county offices)
- Conduct outreach and provide support to individuals enrolled in Medi-Cal during their renewal period to raise awareness and provide support for members with six-month renewals and work reporting requirements
- Contact individuals who have recently lost coverage for procedural and paperwork reasons Assist individuals who are ineligible for Medi-Cal transition to and enroll in Covered California
- Use multiple channels – such as phone calls, texts, emails, and mail-- to ensure members receive timely information and stay informed about updates to their health coverage.
- MCPs are encouraged to collaborate with local county offices to establish data sharing agreements to facilitate outreach and implementation of these policies. MEDIL 23-17 provides a template memorandum of understanding for this purpose.

In addition to outreach, DHCS is also exploring the role MCPs may play in supporting verifications for member work reporting requirement exemptions under H.R.1. Specifically, the Department is evaluating options for MCPs to provide updated utilization data that could help identify members who qualify for exemptions and to assess the potential role of MCP case managers in verifying or coordinating related information. These discussions remain exploratory as DHCS considers operational feasibility and alignment with federal guidance.

Role of Community Health Workers and Navigators

Community health workers (CHW) services were added as a Medi-Cal benefit in 2022. CHWs are a key component of CalAIM's broad transformation of Medi-Cal to create a more coordinated, person-centered, and equitable health system. CHWs are frontline public health workers who provide preventive health services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote physical and mental health and well-being. CHWs are trusted members of their communities and may include individuals known by a variety of job titles, including promotors, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals.

CHWs will be critical in outreach and retention efforts for Medi-Cal members. This includes assisting members with navigating increased frequency of renewals and new work reporting requirements. DHCS considers these activities within scope for CHWs and will provide additional guidance and technical assistance at a later date to support CHWs with carrying out these responsibilities. DHCS plans to partner with CHWs and providers that deliver CHW services to ensure they have tools to educate members on H.R.1 requirements and to support members on completing paperwork related to meeting work requirements and six-month renewals.

The proposed Governor's Budget 2026-27 also includes $4 million ($2 million federal funds and $2 million reimbursements from foundations) for navigators to assist with Medi-Cal eligibility, enrollment, and retention.

Oversight and Monitoring

DHCS plans to integrate new data elements into the Medi-Cal Enrollment and Renewal dashboards to track the impact of H.R.1 implementation, including work reporting requirements. Key metrics will likely include the number of individuals subject to work reporting requirements, the number in compliance with reporting requirements (whether exempt or meeting hours requirements) and the number of coverage discontinuations due to procedural and paperwork disenrollments. Information from this reporting will help guide implementation and ongoing evaluation of the impacts of these new federal requirements.

Appendix

Definition Glossary

- **All County Welfare Directors Letter (ACWDL):** Formal written instructions issued by DHCS to counties that clarify policy, outline system changes, or provide implementation timelines.
- **California Healthcare Eligibility, Enrollment and Retention System (CalHEERS):** The system that supports eligibility determinations and enrollment for Covered California and coordinates data sharing with CalSAWS and DHCS.
- **California Statewide Automated Welfare System (CalSAWS):** The eligibility and case-management system that supports Medi-Cal and other public-assistance programs.
- **CalFresh (Supplemental Nutrition Assistance Program):** California's implementation of the federal SNAP program, providing food assistance to low-income households. CalFresh work requirements may overlap with work and community engagement rules.
- **Children's Health Insurance Program (CHIP):** Federal program providing low-cost health coverage to children in families above Medicaid income thresholds.
- **Churn.** The movement of individuals into and out of Medi-Cal coverage, often due to income changes, failure to complete renewals, or transitions to Covered California.
- **Continuous Coverage Requirement:** A federal policy under the Families First Coronavirus Response Act (FFCRA) that temporarily prohibited states from disenrolling Medicaid beneficiaries during the COVID-19 Public Health Emergency.
- **Cost Sharing for Adults:** Copayments or deductibles ($1–$35 per service) required under H.R.1 for some adult populations starting October 1, 2028. Essential services such as emergency, prenatal, pediatric, and mental-health care remain exempt.
- **County Administrative Funding:** State and federal funds provided to counties to support Medi-Cal eligibility and case-management operations.
- **County Eligibility Offices / County Workers:** Local offices responsible for processing Medi-Cal applications, conducting eligibility determinations, and managing renewals under DHCS supervision.
- **Covered California:** The state's health-insurance marketplace where individuals who lose Medi-Cal eligibility may enroll in subsidized commercial coverage.

- **Death Master File (DMF):** A Social Security Administration database containing verified death records used to terminate coverage for deceased individuals.
- **Deceased Member Verification:** A H.R.1 requirement for counties to review the SSA Death Master File (DMF) at least quarterly to terminate coverage for deceased members.
- **Department of Health Care Services (DHCS):** The California state agency is responsible for administering Medi-Cal and implementing federal and state health-care policies.
- **DHCS Coverage Ambassadors:** A DHCS-led partnership in which counties, MCPs, community organizations, and other trusted messengers collaborate to inform and assist Medi-Cal members during major policy changes.
- ***Ex Parte* Renewal:** An automatic redetermination process that uses federal, state, and county data sources to verify eligibility without requiring action from the member.
- **H.R.1 ("One Big Beautiful Bill Act"):** Federal legislation enacted in 2025 that introduces significant changes to the Medicaid program, including new eligibility, reporting, cost-sharing, and work-engagement requirements.
- **Managed Care Plans (MCPs):** Health-care organizations contracted with DHCS to deliver Medi-Cal benefits. MCPs also support outreach, renewals assistance, and member education.
- **Medi-Cal:** California's Medicaid program that provides free or low-cost health coverage for low-income individuals and families, administered by DHCS in partnership with the state's 58 counties.
- **Medi-Cal Eligibility Division Information Letter (MEDIL):** DHCS policy communication providing clarifications or interim guidance.
- **Procedural and Paperwork Termination / Discontinuance:** A loss of Medi-Cal coverage because the county did not receive timely information needed to continue eligibility, for members who may still meet eligibility requirements.
- **Qualified Non-Citizen (QNC):** An immigration status category was redefined under federal law. H.R.1 amends this definition, effective October 1, 2026, narrowing who qualifies for federal full-scope Medi-Cal coverage.
- **Reducing Duplicate Enrollment Under Medicaid and CHIP:** A H.R.1 requirement that counties regularly verify member addresses and prevent individuals from being enrolled in Medicaid in more than one state.
- **Retroactive Medi-Cal Timeframes:** The look-back period for covering medical costs incurred before application. H.R.1 reduces this from three months to one month for certain adults and two months for all other groups.

- **Six-Month Renewals:** Eligibility reviews required every six months for specific adult populations beginning January 1, 2027; other groups remain on annual renewal schedules.
- **Streamlining Eligibility Final Rule Moratoriums:** Provisions of H.R.1 that pause certain CMS final rules on eligibility and enrollment while maintaining select streamlining measures.
- **Unsatisfactory Immigration Status (UIS):** A federal classification that will newly be applied to certain lawfully present immigrants who no longer qualify as QNCs. Individuals with UIS may receive restricted-scope Medi-Cal.
- **Unwinding (Continuous Coverage Unwinding):** The process DHCS and counties used to return to normal Medi-Cal operations after the federal continuous-coverage requirement ended on March 31, 2023.
- **Work and Community Engagement Requirements:** Federal eligibility rules established by H.R.1 effective January 1, 2027, requiring certain adults to work, study, volunteer, or participate in qualifying activities at least 80 hours per month unless exempt.

Resources

State Guidance

DHCS will release regular guidance in order to assist counties with frequently asked questions, policy changes, policy clarifications and other useful information surrounding H.R.1. The guidance can be found at the following links and will be updated as more guidance is available.

Guidance Documents

Document	Date Issued	Title
MEDIL 25-18	August 7, 2025	Medi-Cal Impacts from House Resolution (H.R.1)
ACWDL 25-31	December 30, 2025	Six-Month Renewals for New Adult Group Requirements
ACWDL 25-30	December 30, 2025	Work and Community Engagement Requirements for New Adult Group

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Updated November 25, 2024

Chart Book: SNAP Helps Struggling Families Put Food on the Table

The Supplemental Nutrition Assistance Program (SNAP) is the nation's most important anti-hunger program.

- **SNAP reaches millions of people who need food assistance.** It's one of the few means-tested government benefit programs available to almost all households with low incomes. For basic information on the program, see "Policy Basics: The Supplemental Nutrition Assistance Program" and "A Quick Guide to SNAP Eligibility and Benefits."
- **SNAP promotes long-term health and well-being, especially for children.** Research shows that SNAP reduces poverty and food insecurity, and that over the long term, these impacts lead to improved health and economic outcomes, especially for those who receive SNAP as children. For more on the long-term impacts of SNAP, see "SNAP Is Linked with Improved Health Outcomes and Lower Health Care Costs."

This chart book highlights some key characteristics of the 41 million people using the program in a typical month, trends and data on program administration and use, and data on SNAP's effectiveness in fighting food insecurity and poverty and improving health, education, and labor market outcomes. It complements more detailed analyses on particular aspects of SNAP available on our website. Also, new data for some material in this chartbook were released before its completion. We will be updating this piece accordingly.

Part I: SNAP Responds to Changes in Poverty and the Economy

Part II: Benefits Are More Adequate But Still Modest After 2021 Thrifty Food Plan Revision

Part III: SNAP Helps Families Afford Adequate Food, Reduces Food Insecurity and Poverty

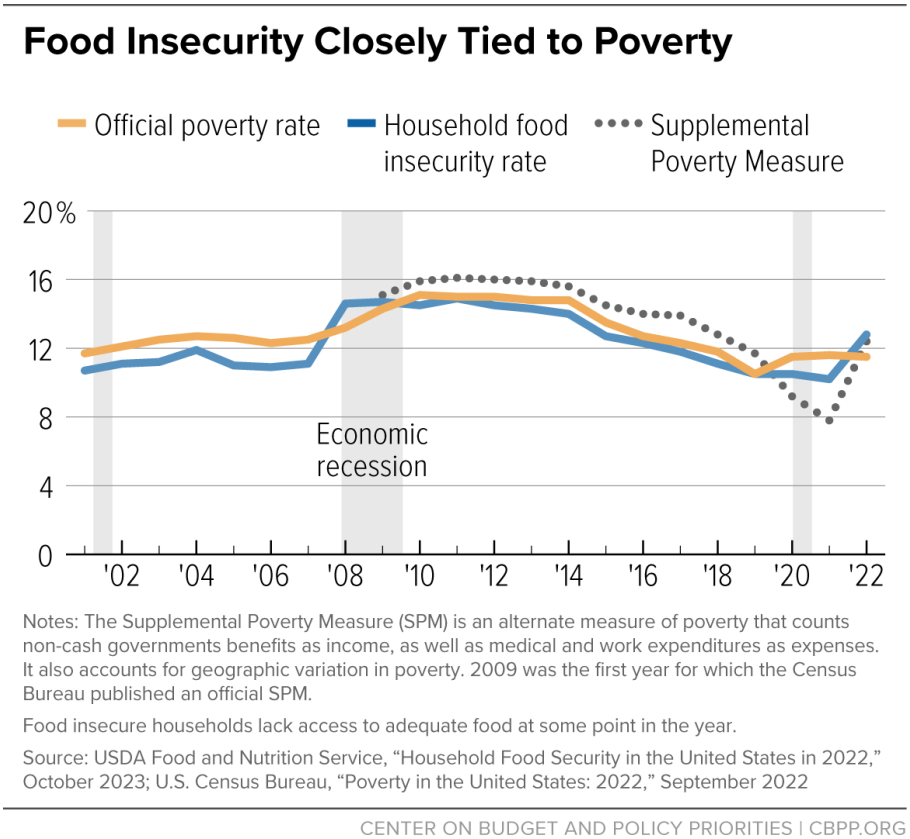
Part IV: SNAP May Mitigate Persistent Racial and Ethnic Disparities in Food Insecurity

Part V: SNAP Is Linked With Improved Health Outcomes

Part VI: SNAP Serves People in Particular Need of Assistance

Part VII: SNAP Supports Working Families and Those Unable to Work
Part VIII: SNAP Reaches Most Eligible People, With Some Important Exceptions
Part IX: SNAP Is Efficient
Part X: SNAP Is an Important Public-Private Partnership
Part XI: Food Assistance in Puerto Rico

Part I: SNAP Responds to Changes in Poverty and the Economy



Trends in food insecurity are closely tied to trends in poverty. Both poverty and food insecurity typically rise in response to economic downturns, as more people experience income or job losses. Following the Great Recession of 2007-09, for example, the share of the U.S. population in poverty rose to 15.1 percent in 2010, according to Census Bureau estimates. The ensuing economic recovery was slow; the poverty rate did not decline significantly until 2015 and did not reach pre-recession levels until 2016. In 2019, the last year before the COVID-19 pandemic caused a global recession, the poverty rate was 10.5 percent, the lowest on record in data going back to 1959.

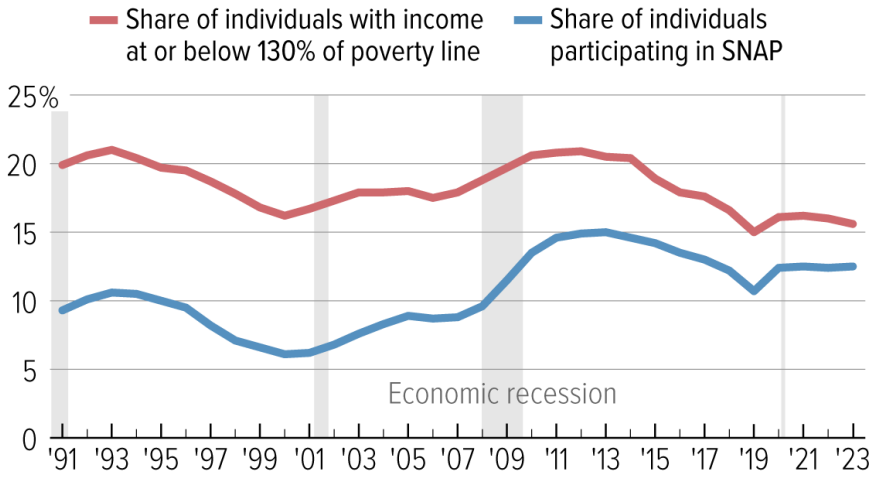
Food insecurity followed a generally similar trend. The national household food insecurity rate — that is, the share of households who lacked access to adequate food at some point during the year — rose in response to the Great Recession, reaching 14.9 percent in 2011. It declined over subsequent years, to 10.5 percent in 2019.

The COVID-19 recession was the shortest on record, and the recovery was buoyed by robust federal relief measures. A strong government response, including temporary pandemic SNAP Emergency Allotments and a 15 percent increase to maximum SNAP benefits, averted large increases in food insecurity and poverty during the pandemic.[1] The poverty rate using the Supplemental Poverty Measure (SPM), which — unlike the official measure — counts non-cash government assistance as income and accounts for taxes and other expenses, actually fell to a record low of 7.8 percent in 2021, while food insecurity remained statistically unchanged between 2019 and 2021.[2]

With the expiration of the pandemic relief programs and a sharp increase in food inflation in 2022, SPM poverty and food insecurity both increased in 2022, further evidence that government aid is critical to alleviating hardship for struggling families.[3]

Several measures may have prevented food insecurity from being even higher in 2022. Most notably, 2022 was the first full year since USDA revised the Thrifty Food Plan (TFP), the basis of SNAP benefit levels, following a directive supported on a bipartisan basis in the 2018 farm bill to periodically reevaluate the TFP. The revision increased SNAP's modest average benefits by about $1.40 per person per day, to just $6.20 per person per day in fiscal year 2024. Additionally, most states were still issuing Emergency Allotments in 2022, and Pandemic EBT grocery benefits were available to school-age children, as they had been for the summer of 2021, to compensate for the free or reduced-price school meals children missed when schools were closed for the summer.[4] (See box, "Several Major Factors Have Affected SNAP Benefits in Recent Years.")

SNAP Tracks Changes in Share of Population Near or Below the Poverty Line



Note: Poverty estimates are annual estimates. SNAP shares of resident population are calendar year averages.

Sources: U.S. Census Bureau, U.S. Department of Agriculture

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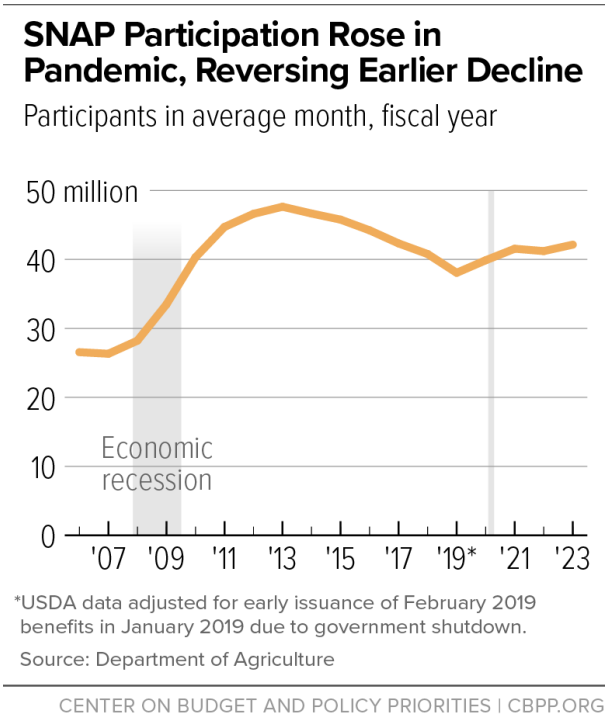
The number of SNAP participants rises due to economic downturns and falls as the economic recovery reaches more low-income households. After unemployment insurance, SNAP historically has been the most responsive federal program in assisting families and communities during economic downturns. SNAP grew rapidly in response to each of the four recessions in the last 30 years, as more people lost employment or income and more households qualified for benefits and applied for help.



The COVID-19 pandemic reversed a long decline in SNAP caseloads. Caseloads expanded significantly between 2007 and 2011, due largely to the Great Recession and subsequent slow recovery.[5] Caseloads peaked at 47 million in December 2012, then declined over the next six years. SNAP expanded again in 2020 and 2021, but by a smaller amount than in the Great Recession, to meet the needs of struggling households during the pandemic. Caseloads have since remained essentially flat nationally.[6] The Congressional Budget Office (CBO) projects that caseloads will enter a new period of decline starting in 2024.[7]

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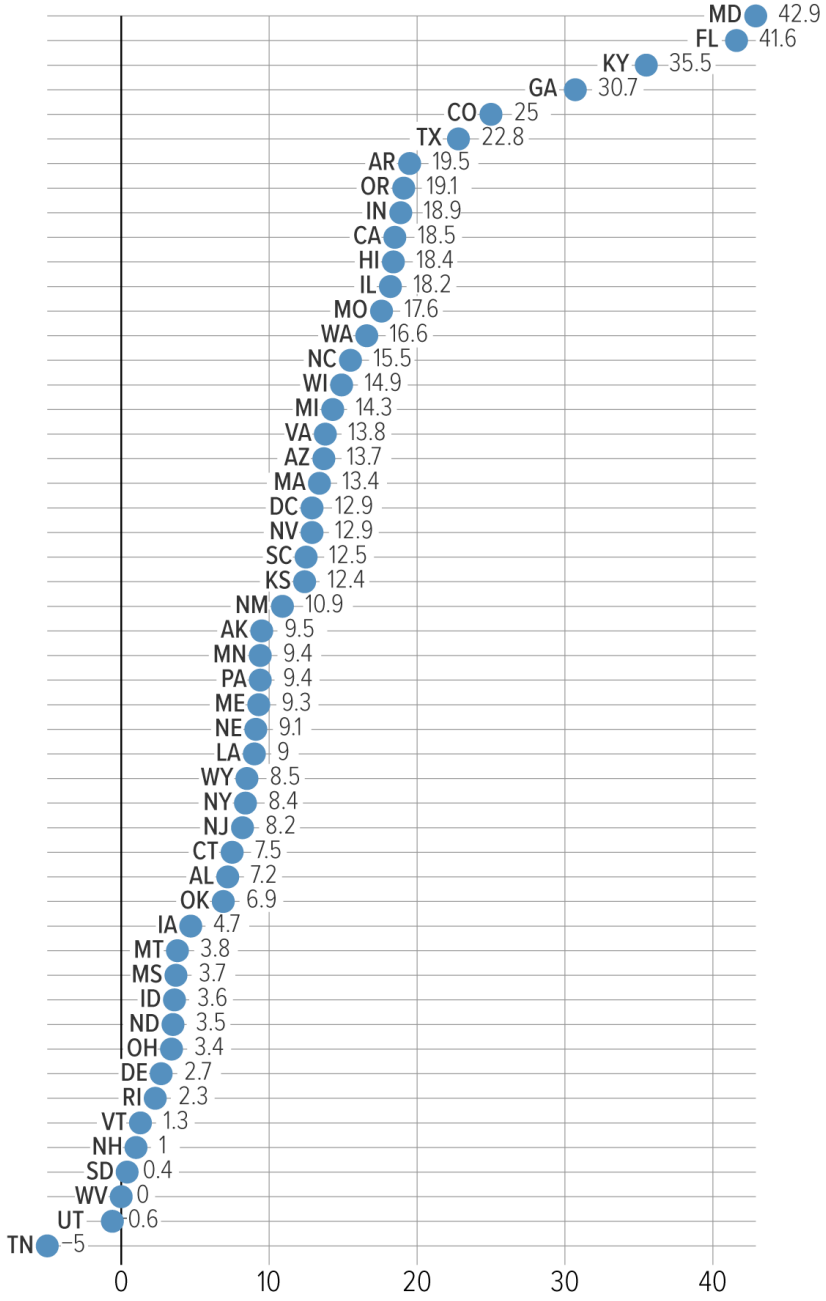
State SNAP Caseloads Grew Rapidly in Pandemic's First Months

Percent change in SNAP participants by state, February to June 2020



Note: North Dakota's June 2020 caseload estimate appears to be an anomaly, so the caseload change for this state is measured from February 2020 to May 2020.

Source: CBPP calculations of U.S. Department of Agriculture data

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SNAP enrollment grew rapidly in the first few months of the pandemic. Most of the country experienced significant caseload growth in the first few months of the COVID-19 pandemic in early 2020. Between February and June 2020, all but two states saw caseload increases, which averaged about 15 percent nationally.

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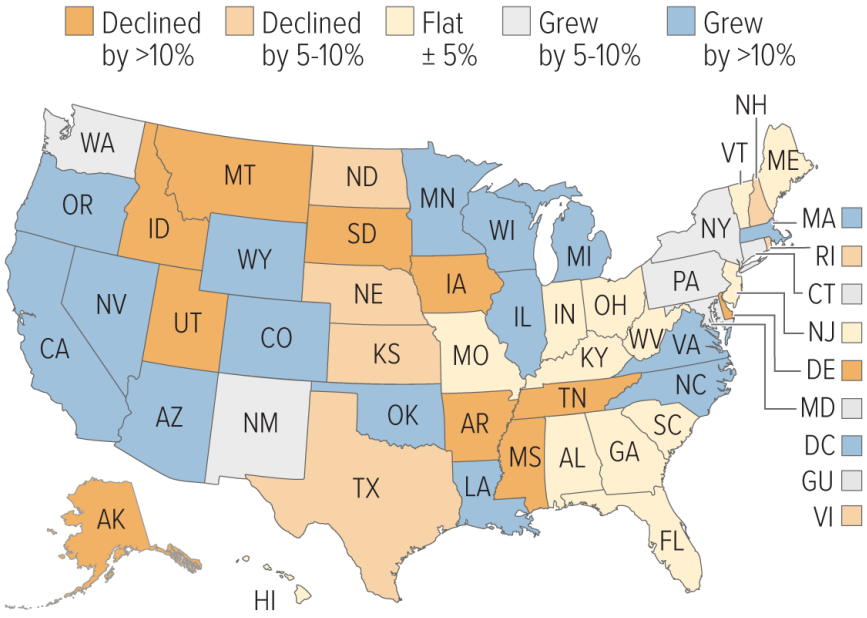
Changes in SNAP Caseloads During COVID-19 Pandemic Varied by State

Percentage change in SNAP participants as share of the population between fiscal year 2019 and fiscal year 2023



Note: USDA data adjusted for early issuance of February 2019 benefits in January 2019 due to government shutdown.

Source: CBPP calculations from USDA program data and Census Bureau population estimates.

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Enrollment relative to pre-pandemic levels varies by state. After growing quickly in the first months of the pandemic, the national SNAP caseload has been flat at 41 to 42 million people. But there has been significant variation across states. Between 2019 and 2023, the share of the population participating in SNAP declined in 16 states and the U.S. Virgin Islands, remained roughly unchanged in 13 states, and grew in 21 states, the District of Columbia, and Guam.[8]

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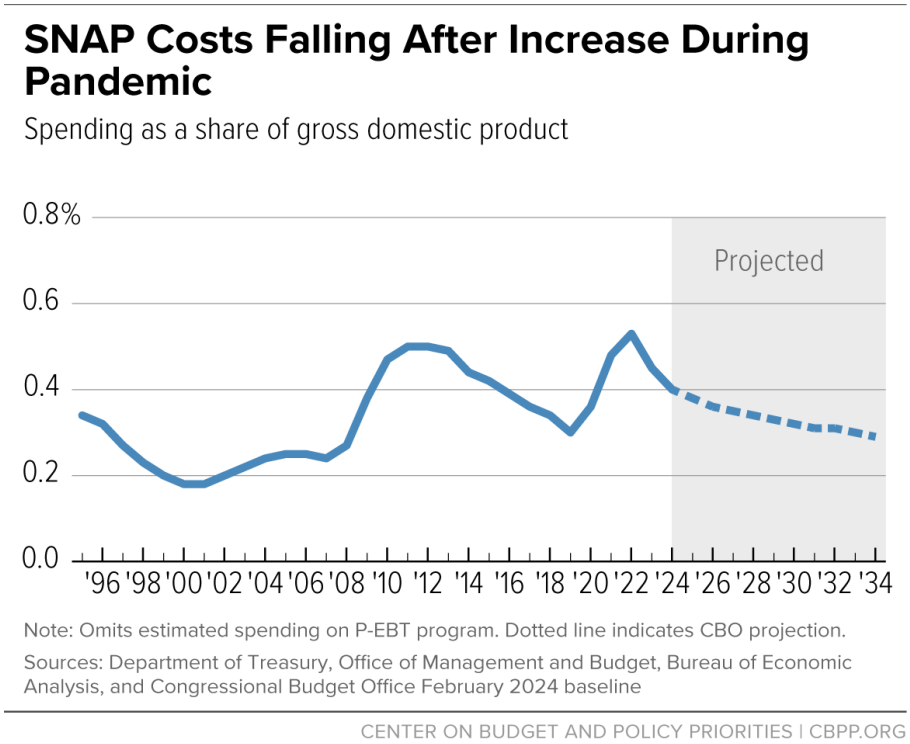


SNAP spending increased during the pandemic but has since fallen and is expected to approach pre-pandemic levels as a share of the economy. Measured as a share of gross domestic product (GDP), SNAP spending rose in response to the Great Recession due to increased participation and the 2009 Recovery Act's temporary SNAP benefit increase. It then fell for six years during the recovery. Similarly, SNAP spending increased during the pandemic due to higher participation and temporary benefit increases, as well as to a revision to the Thrifty Food Plan that better aligned SNAP benefits with current science-based dietary guidelines and food consumption patterns.

SNAP spending reached a new peak in 2022 but then fell in 2023 with the expiration of the temporary pandemic benefits. (Spending fell in nominal terms as well, by 9 percent.) CBO expects SNAP spending to decline again in 2024 and in future years and to approach 2019 levels by 2034.

Unlike health care programs and Social Security, SNAP doesn't face demographic or programmatic pressures that would cause its costs to grow faster than the economy over the long term. SNAP thus doesn't contribute to the nation's long-term fiscal problems.

Several Major Factors Have Affected SNAP Benefits in Recent Years

SNAP benefits are adjusted annually (at the start of the federal fiscal year in October) to account for inflation. Typically, those changes are relatively minor. In recent years, however, SNAP households have experienced significant adjustments in their SNAP benefits, for three reasons.

First, Congress enacted two temporary benefit increases in response to increased hardship during the COVID-19 public health emergency:

- Emergency Allotments, which ended after the February 2023 issuance.[a]
- A temporary 15 percent increase in SNAP benefits, which expired at the end of September 2021.

Second, USDA revised the Thrifty Food Plan (TFP), which is used to set SNAP benefit levels, to more accurately reflect the cost of a healthy diet. (The TFP is USDA's estimate of a nutritionally adequate diet that low-income households can purchase and prepare, assuming they take significant steps to stretch their food budget.) Congress directed USDA to undertake this science-driven update to the TFP in the bipartisan 2018 farm bill. This update went into effect in October 2021 and raised maximum SNAP benefits by 21 percent in fiscal year 2022 and going forward, compared to what they otherwise would have been. The revision increased SNAP's modest average benefits by about $1.40 per person per day, to just $6.20 per person per day in fiscal year 2024.[b]

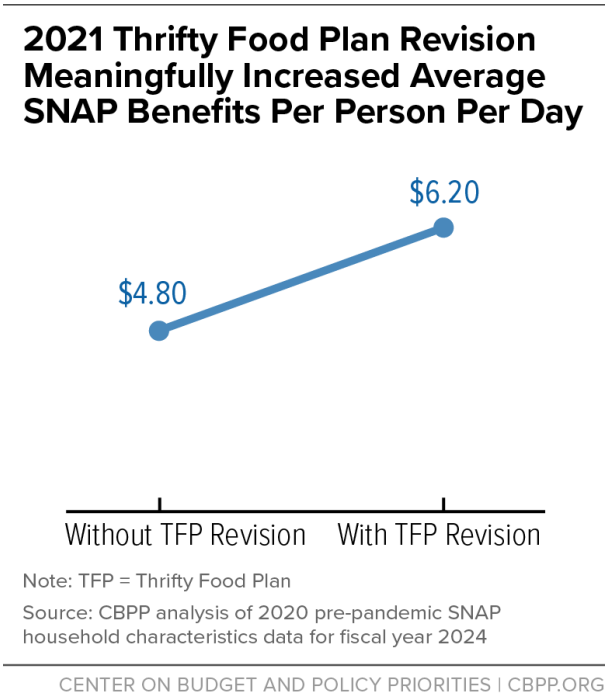
Third, food prices rose rapidly starting in the fall of 2021 and are about 27 percent above pre-pandemic levels.[c] Because SNAP benefit levels (as well as several other program rules) are adjusted annually for inflation, benefits increased in fiscal years 2023 and 2024 in most jurisdictions to maintain their purchasing power.

[a] When the allotments expired, households receiving SNAP in states still issuing allotments experienced a substantial benefit cut: $84 per person per month, on average.

[b] Joseph Llobrera, Matt Saenz, and Lauren Hall, "USDA Announces Important SNAP Benefit Modernization," CBPP, August 25, 2021, https://www.cbpp.org/research/food-assistance/usda-announces-important-snap-benefit-modernization. When the TFP revision went into effect in October 2021, USDA applied the same percent increase to maximum benefits for Alaska and Hawai'i. Recently, USDA completed a more detailed revision for Alaska and Hawai'i to account for geographical differences. As a result, lower maximum benefits will be phased in for Hawai'i in the coming years. In fiscal year 2024 the maximum benefit was about 2 percent lower in nominal terms (or about $10 a month) than in fiscal year 2023.

[c] Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers (CPI-U) food at home for fiscal year 2024 compared to fiscal year 2019.

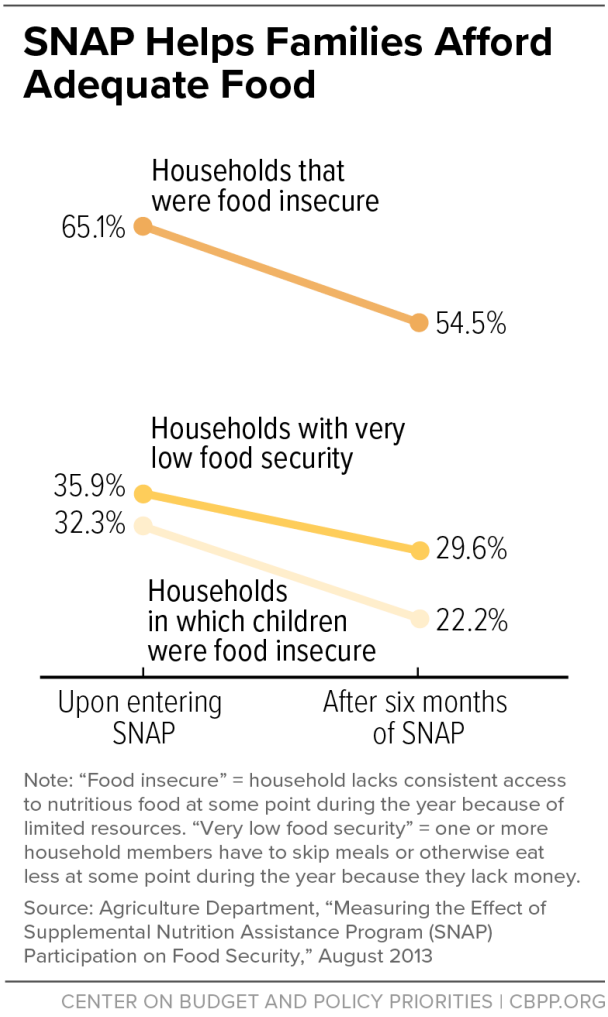
Part II: Benefits Are More Adequate But Still Modest After 2021 Thrifty Food Plan Reevaluation



SNAP benefits are modest. SNAP benefits are higher than prior to the pandemic due to the Thrifty Food Plan revision (see box, "Several Major Factors Have Affected SNAP Benefits in Recent Years") and cost-of-living adjustments to reflect high food inflation in recent years. Benefits nevertheless remain modest. In fiscal year 2024 the Thrifty Food Plan update increased benefits by $1.40 per person per day, to about $6.20 per person per day. This update better aligned SNAP benefits with the cost of a healthy diet according to modern dietary recommendations, and it lifted an estimated 2.4 million people, including more than 1 million children, above the poverty line.[9]

SNAP benefits are based on need: very low-income households receive larger benefits than households with more income since they need more help affording an adequate diet. The benefit formula assumes that families will spend 30 percent of their net income for food; SNAP provides enough additional benefits to meet the cost of the Thrifty Food Plan. A family with no net income has no money for food and thus receives the maximum benefit amount, which equals the cost of the Thrifty Food Plan for a household of its size.

Part III: SNAP Helps Families Afford Adequate Food, Reduces Food Insecurity and Poverty



SNAP helps families put enough food on the table. Studies have found that SNAP benefits reduce food insecurity, which occurs when households lack consistent access to nutritious food because of limited resources. One study found that participating in SNAP reduced households' food insecurity by as much as 10 percentage points and reduced "very low food security," which occurs when one or more household members have to skip meals or otherwise eat less because they lack money, by about 6 percentage points.[10] Because SNAP enables low-income households to spend more on food than their limited budgets would otherwise allow, it helps ensure that they have enough to eat. SNAP may also reduce racial and ethnic disparities in food insecurity.

Although SNAP has been proven effective in reducing food insecurity, nearly half of the households who received SNAP benefits in 2022 still experienced food insecurity.[11] Also, there is growing evidence that the recent cut in benefits when the pandemic Emergency Allotments ended resulted in greater food insecurity.[12] These facts highlight the importance of protecting and improving SNAP benefits.

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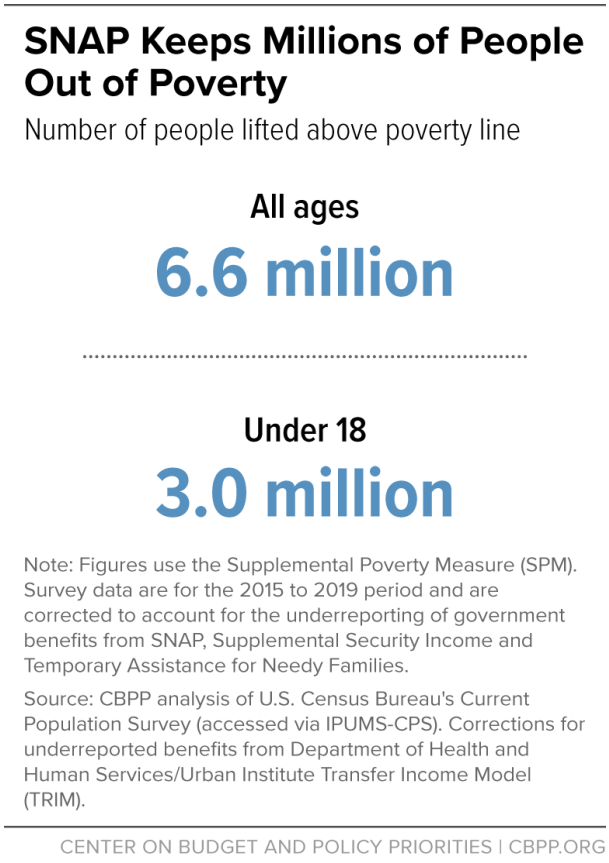
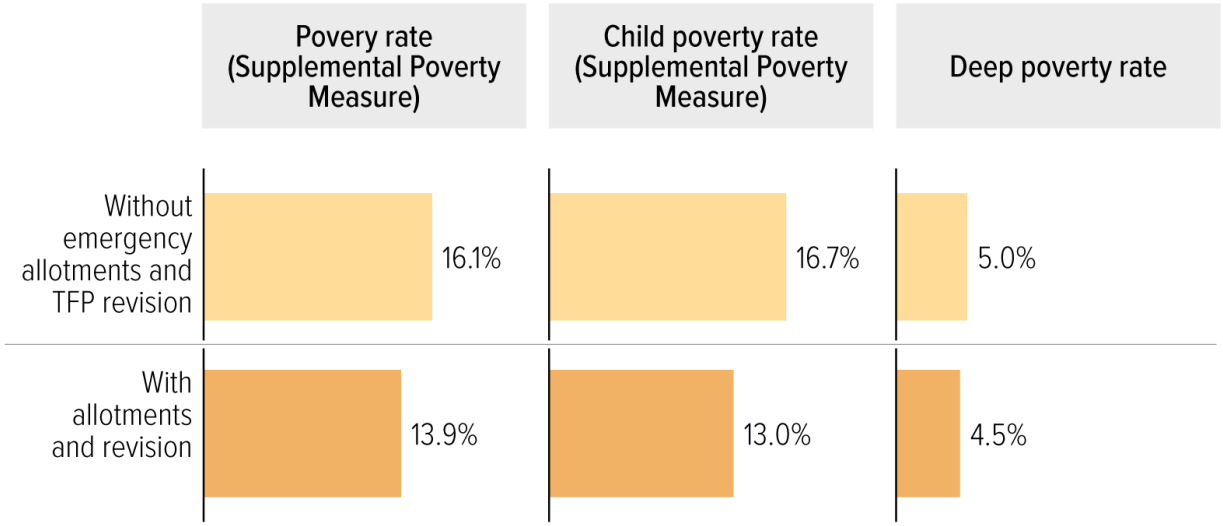


SNAP lifts millions of households out of poverty. By providing benefits that can only be used to purchase food, SNAP forms an important part of a low-income household's budget. A CBPP analysis using the government's Supplemental Poverty Measure (which counts SNAP as income) and correcting for underreporting in government surveys found that SNAP kept 6.6 million people above the poverty line before the COVID-19 pandemic, including 3 million children.[13] A related CBPP analysis found that SNAP has one of the strongest anti-poverty effects of any program.[14]

Higher SNAP Benefits in Pandemic Lifted More People Out of Poverty

Quarterly poverty rate



Notes: The authors estimated the number of people in poverty in the fourth quarter of calendar year 2021, had the Thrifty Food Plan revision and temporary SNAP Emergency Allotments (in states that still implemented them at the time) not been in effect.

The Supplemental Poverty Measure (SPM) is an expanded poverty measure that incorporates a household's non-cash income such as government benefits and tax credits, and counts living expenses such as medical expenses, work-related commuting costs and medical expenses. Deep poverty rate is the share of people with resources below half of the SPM poverty threshold.

Source: Urban Institute, "Effect of the Reevaluated Thrifty Food Plan and Emergency Allotments on Supplemental Nutrition Assistance Program Benefits and Poverty," August 2022.

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Increasing SNAP benefits has helped families afford adequate food. Previous increases have been effective at reducing poverty and food insecurity, evidence suggests. Research on the food security of SNAP recipients during the Great Recession found that very low food security fell in 2009 — the same year the SNAP benefit increase from the 2009 Recovery Act took effect — among SNAP-eligible households with low incomes.[15] More recently, a study of the effect of temporary pandemic benefits on SNAP households found that the Emergency Allotments and Thrifty Food Plan revision kept some 6.5 million people out of poverty in the fourth quarter of 2021. The poverty reductions were especially large for Black and Latino people.[16]

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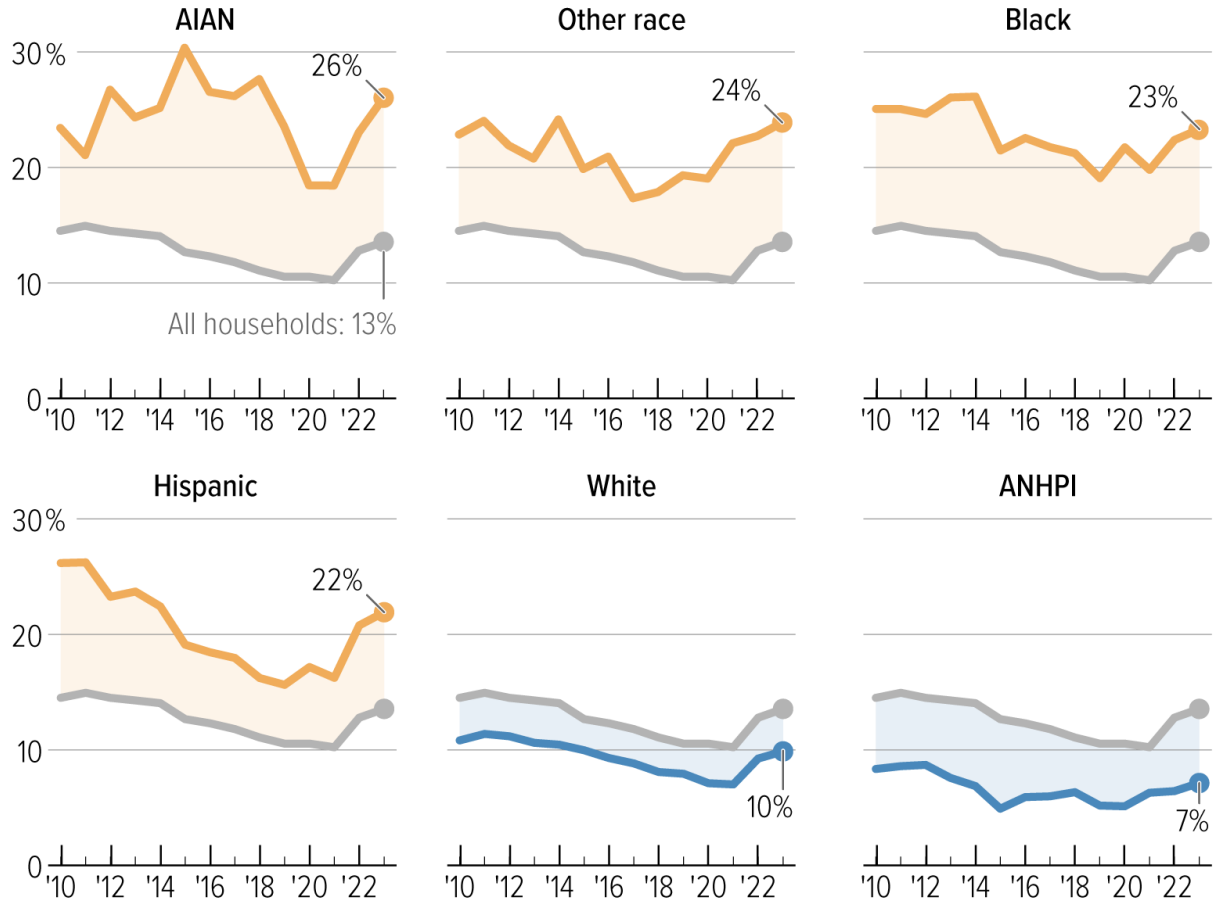
Part IV: SNAP May Mitigate Persistent Racial and Ethnic Disparities in Food Insecurity

Hunger Greater Among People of Color, Reflecting Inequities

Food insecurity rate, by race and ethnicity, vs. rate for all households



Note: AIAN = people who are American Indian and Alaska Native. Other race = people who are more than one race. ANHPI = people who are Asian, Native Hawaiian, or Pacific Islander. Hispanic households may be of any race. Race and ethnicity for the household are based on that of the household reference person (in whose name the housing unit is owned or rented).

Source: U.S. Department of Agriculture, Current Population Survey Food Security Supplement 2010-2023

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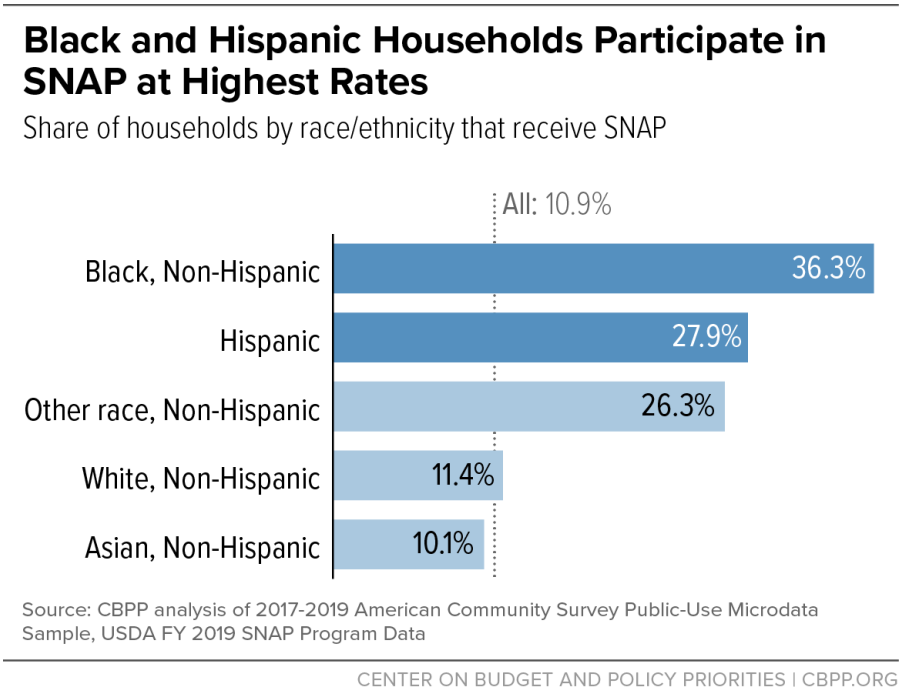
Racial and ethnic disparities in food insecurity rates are wide and persistent. Long-standing racial disparities, deeply rooted in racism and discrimination, have created starkly unequal opportunities and outcomes in education, employment, health, and housing, leading to substantial racial gaps in both income and wealth.[17] Partly for this reason, food insecurity — which is far more common among individuals and families with lower incomes — is far more common among people of color as well.

For decades, the food insecurity rates for households that are American Indian or Alaska Native, Black, Hispanic, or multiracial have been at least twice the white rate. Research suggests that the causes of the inequities in food insecurity between Black and white households, for instance, are systemic and lie outside the control of individuals.[18] Past and present racism and systemic bias create

economic barriers that can affect a person's income. Lack of income and other resources, in turn, increases the risk of food insecurity.[19]



Certain communities of color are disproportionately likely to participate in SNAP to help meet their food needs. Black, Hispanic, and multiracial households have higher poverty rates than white households. They also have higher rates of food insecurity than white households.[20] These communities of color are therefore more likely to be eligible for, and participate in, SNAP.

Twenty-six percent of SNAP households are headed by a Black, non-Hispanic person and 22 percent are headed by a Hispanic person. These figures exceed their shares of the general U.S. population (12 percent and 20 percent, respectively).[21]

Studies suggest SNAP mitigates racial disparities in food insecurity and poverty. While Black households are more likely to be food insecure than white households overall, one study found that, among households participating in SNAP, this pattern was reversed: Black households were less likely than white households to be food insecure.[22]

Another study found that, among individuals who experienced poverty in childhood, those who had access to food stamps (now SNAP) in childhood were less likely to experience poverty as young adults than those who didn't have access to food stamps, and the effect was stronger for Black than for white individuals.[23]

Still another study found that SNAP benefits, by increasing food expenditures, reduce the gap between what households spend on food and the estimated level of food spending that households need to be food secure. It also found that the reduction is greater for Black and Hispanic households than for white households.[24]

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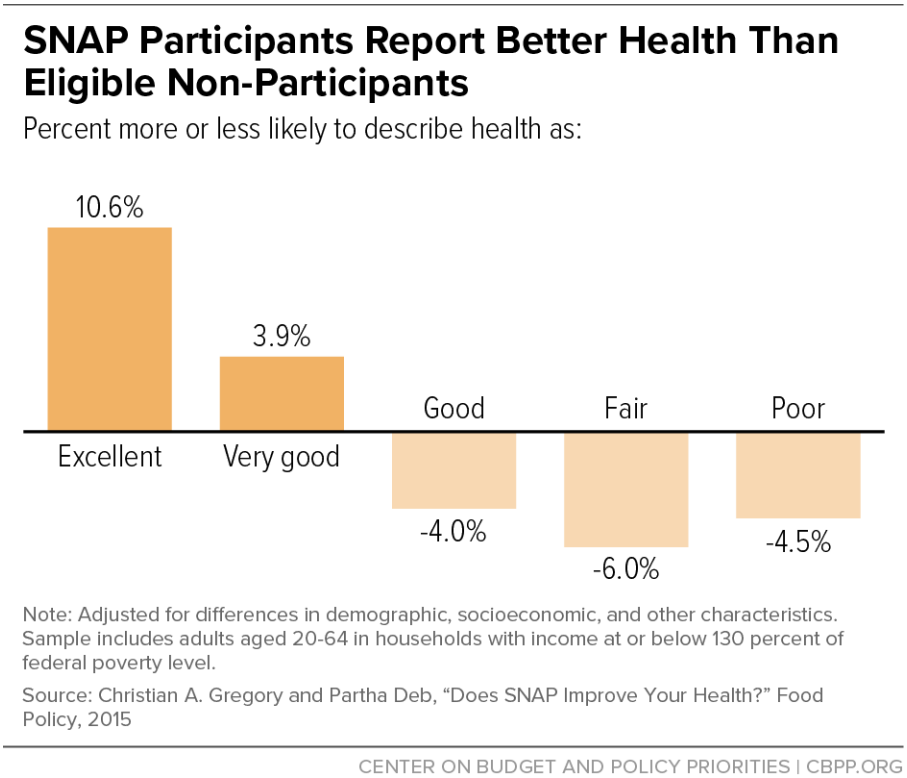
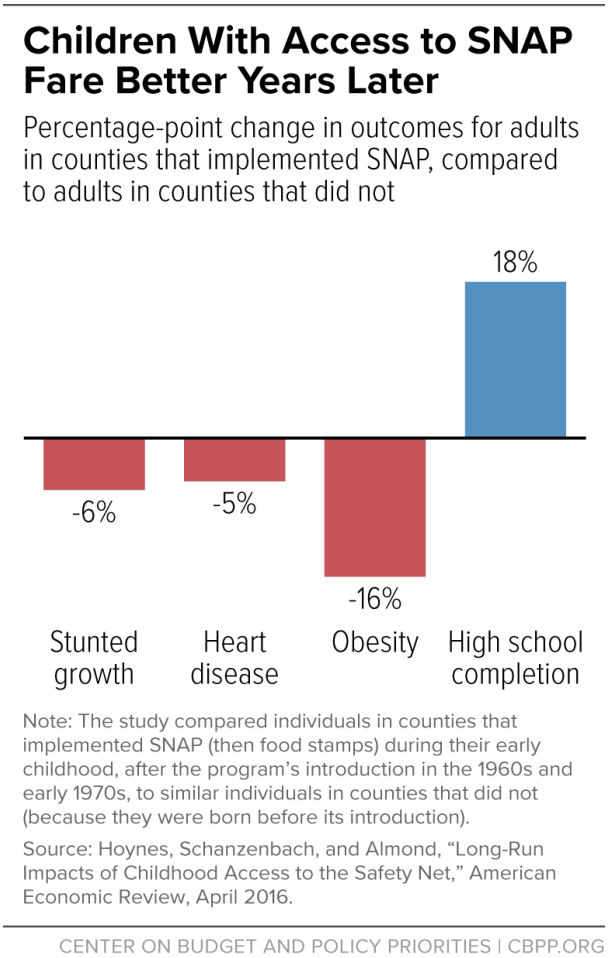
Part V: SNAP Is Linked With Improved Health Outcomes



SNAP is associated with improved health. The stress that food-insecure families face because they can't consistently put healthy food on the table, along with the health effects of unpredictable or intermittent meals, may contribute to a higher risk of chronic conditions and other adverse health outcomes. Because SNAP reduces food insecurity and associated stress and frees up income for households to buy healthier food, SNAP may be a path toward better health.

Research links SNAP with several improved health outcomes. After adjusting for differences in demographic, socioeconomic, and other characteristics, adults who participate in SNAP are more likely to assess their own health as excellent or very good, as are parents when assessing their child's health. Adults who receive SNAP have fewer sick days, make fewer visits to a doctor, are less likely to forgo needed care because they cannot afford it, and are less likely to exhibit psychological distress.

Other researchers have shown that children receiving SNAP are less likely than low-income non-participants to be in fair or poor health or underweight, and their families are less likely to make trade-offs between paying for health care and paying for other basic needs, like food, housing, heating, and electricity. Research has also shown that elderly SNAP participants are less likely than similar non-participants to cut back on prescribed medications due to cost.



Access to SNAP can improve health and educational outcomes. When researchers compared the long-term outcomes of individuals in different areas of the country as SNAP gradually expanded nationwide in the 1960s and early 1970s, they found that disadvantaged children in counties that provided access to food stamps in early childhood and whose mothers had access during their pregnancy had better health and educational outcomes as adults than children in counties that did not provide access to food stamps. Among other things, children in counties with access to food stamps were less likely in adulthood to have stunted growth, be diagnosed with heart disease, or be obese. They also were more likely to graduate from high school. [25]

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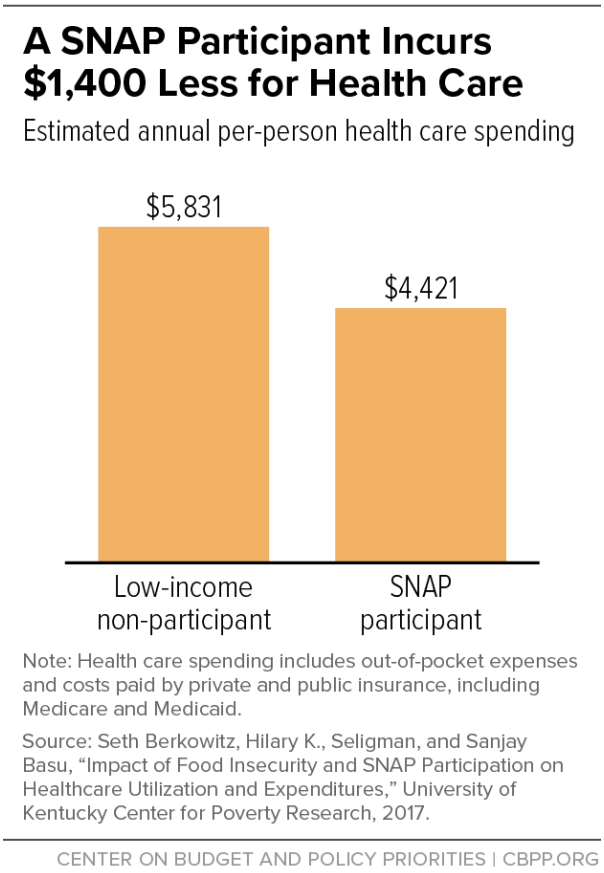

SNAP participation is also linked with lower overall health care expenditures. An analysis of national data on overall health care expenditures links SNAP participation to lower health care costs. On average, after controlling for factors expected to affect spending on medical care, low-income adults participating in SNAP incur about $1,400, or nearly 25 percent, less than non-participants in medical care costs in a year, including those paid by private or public insurance.[26]

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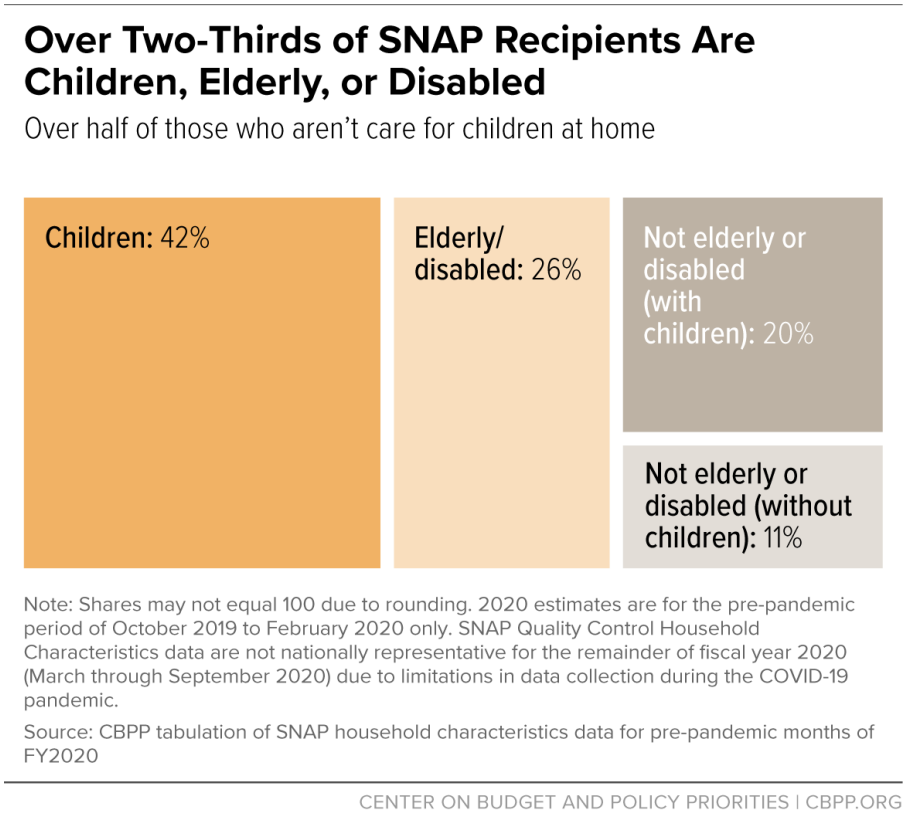
Part VI: SNAP Serves People in Particular Need of Assistance



A large majority of SNAP participants are children, older adults, or people with disabilities. Roughly 2 in 5 participants are children, and most non-elderly adult participants without disabilities live with children.

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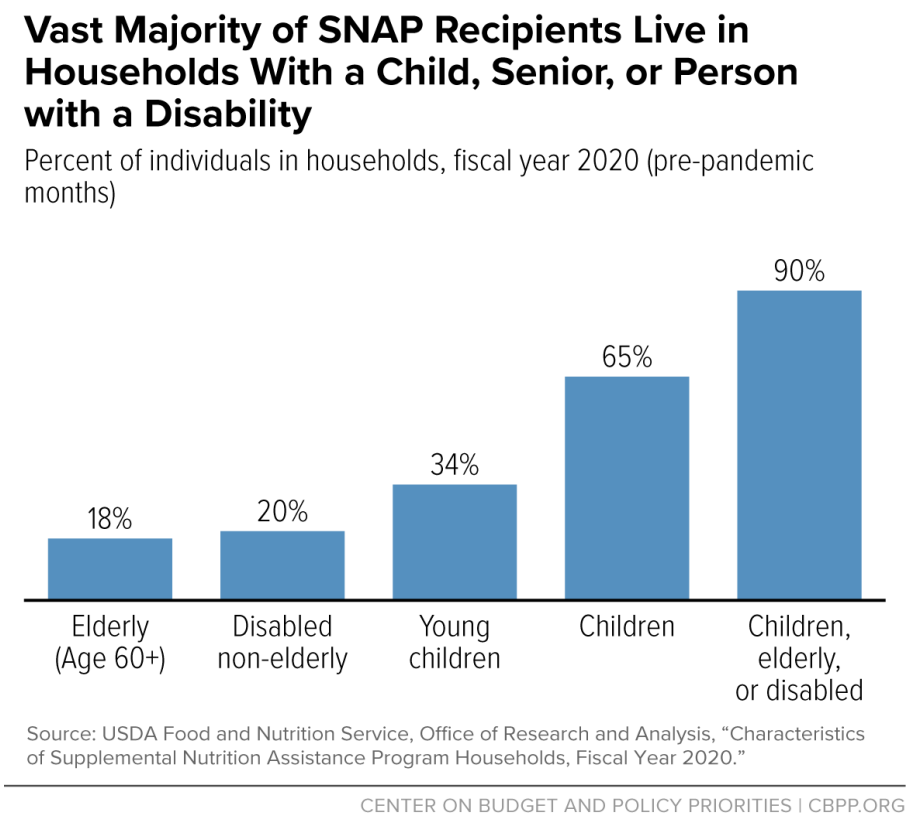

SNAP serves families in particular need of assistance. Fully 90 percent of participants are in households that contain a child under age 18, an elderly person 60 years or older, or an individual with disabilities.

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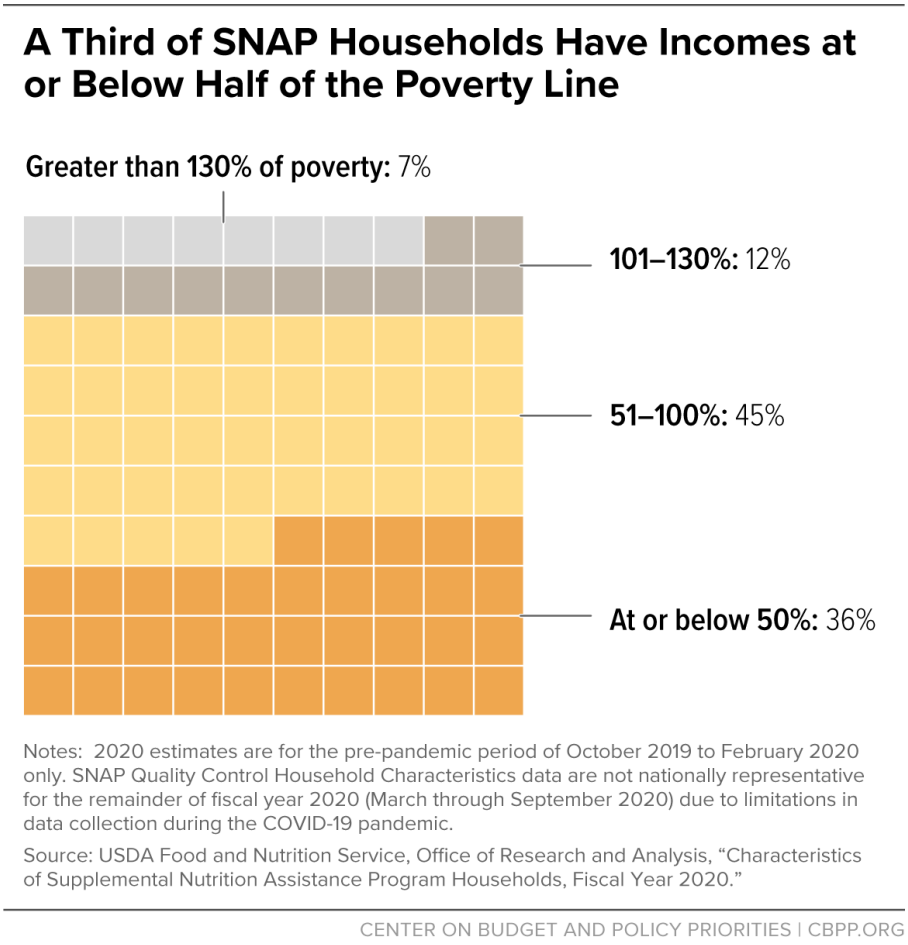

SNAP households have very low incomes. Over 80 percent of SNAP households have gross incomes at or below the poverty line ($24,864 for a family of three in fiscal year 2024, and $14,580 for a person living alone, such as an elderly widow). Most of the rest have incomes between 101 and 130 percent of poverty. Thirty-six percent of SNAP households have incomes at or below *half* of the poverty line.

Some 92 percent of SNAP benefits go to households below the poverty line; about 54 percent go to households at or below half of the poverty line.

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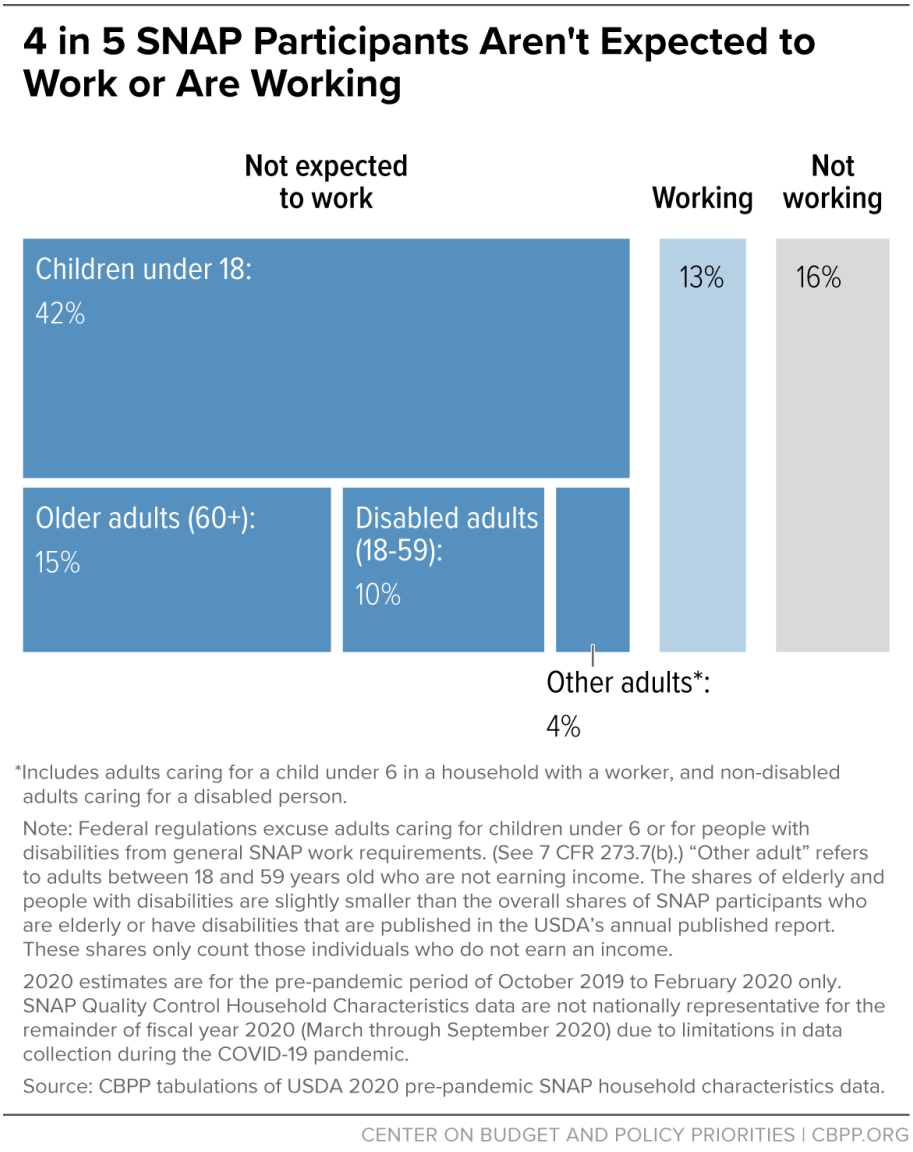
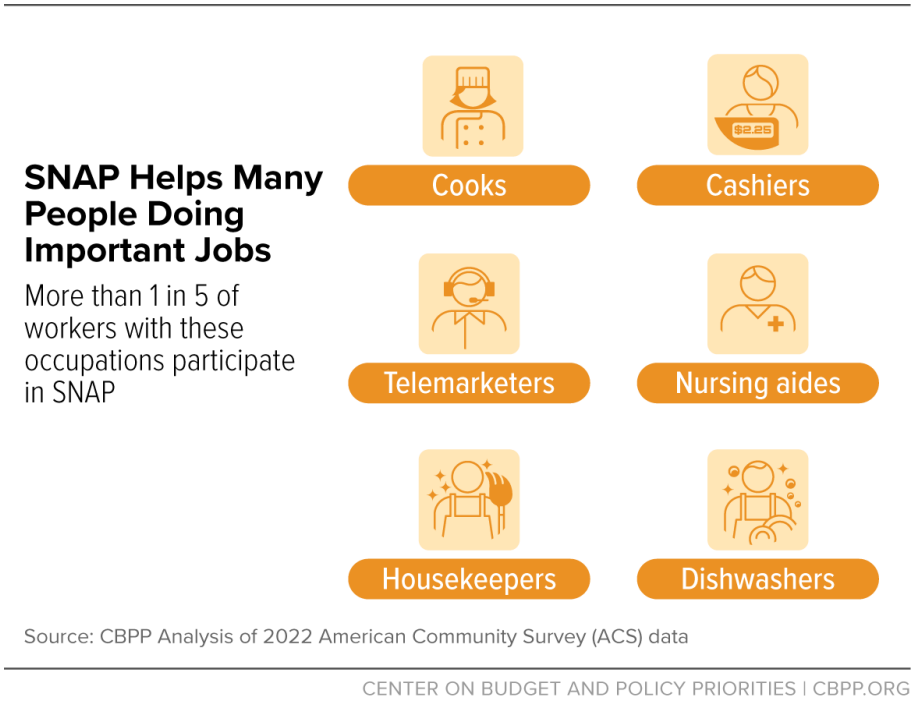
Part VII: SNAP Supports Working Families and Those Unable to Work



Most SNAP participants are not expected to work. In a typical month during the pre-pandemic months of 2020, 71 percent of SNAP recipients weren't expected to work because they were children, elderly, individuals with disabilities, or caring for a family member with a disability in their home or for a child under age 6 where another household member was working.



SNAP supports workers in low-paying jobs. Close to two-thirds of workers who receive SNAP benefits work in major occupation groups such as service, professional, transportation and material moving, and office and administrative support. Common occupations of SNAP participants include cooks, cashiers, telemarketers, nursing assistants, housekeepers, and dishwashers.

In many of these jobs, workers earn low wages and have irregular work schedules, with fewer or less consistent hours than they would like. As a result, they may use SNAP benefits to supplement their low incomes. In addition, workers often cycle in and out of these jobs and participate in SNAP during periods of unemployment or underemployment.[27]

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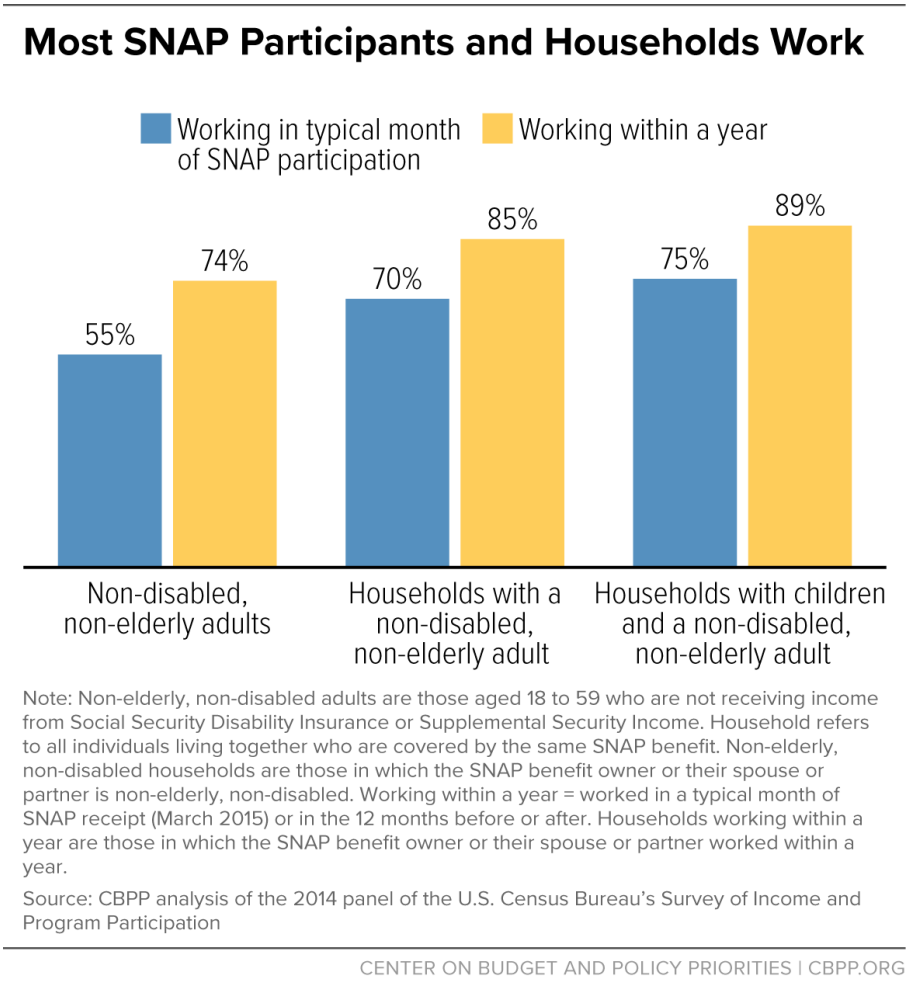


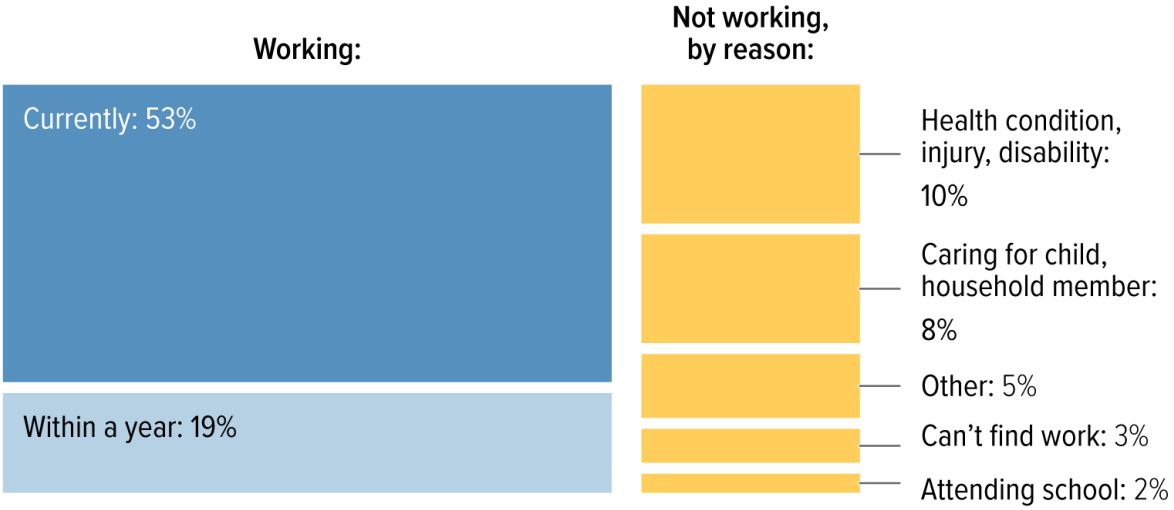
Most SNAP participants work, and many turn to SNAP when they are between jobs. The low pay and instability in many low-paying jobs can contribute to income volatility and job turnover. Low-paid workers, including many who participate in SNAP, are more likely than other workers to experience periods when they are out of work or when their monthly earnings drop, at least temporarily. These dynamics lead many adults to participate in SNAP temporarily, often while between jobs or when their work hours are cut. Others, such as workers with steady but low-paying jobs or those unable to work, participate over the longer term.

A CBPP analysis found that 55 percent of non-elderly adults without a disability who participated in SNAP in a typical month in 2015 worked in that month, while 74 percent worked in the 12 months before or after that month. Work rates were even higher for two other groups: households with a non-disabled, non-elderly adult and households with children and a non-disabled, non-elderly adult. All three groups showed a higher work rate when measured over the longer time period (25 months versus one month) — evidence that SNAP recipients' joblessness is often just temporary.

Another CBPP analysis found that 86 percent of SNAP households that included a non-disabled working-age adult but no minor children had earned income in 2021.[28]

Most Adult SNAP Participants Who Don't Work Have Caretaking Responsibilities or Health Conditions

Participants' work status in typical month, 2015



Note: Sample includes adults aged 18-59, not receiving disability benefits, who were participating in SNAP in March 2015. The reasons for not working are those reported in the given month in the middle of the 25-month period observed, but here only shown for those who did not work during the 25-month period.

Source: CBPP analysis of the 2014 panel of U.S. Census Bureau's Survey of Income and Program Participation

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Many non-elderly, non-disabled SNAP participants who are not working in a typical month while they are participating in SNAP have recently worked or will soon work, or have caregiving responsibilities, or face barriers to work. The CBPP analysis also found that of those adults who were not working in the month studied, close to half worked in either the year before or the year after that month. Many people participate in SNAP while between jobs and continue to work in most months when receiving SNAP. Those who did not work over the 25-month period studied most frequently reported they had health issues that affected their ability to work, had caregiving responsibilities, couldn't find work, or were attending school.[29]

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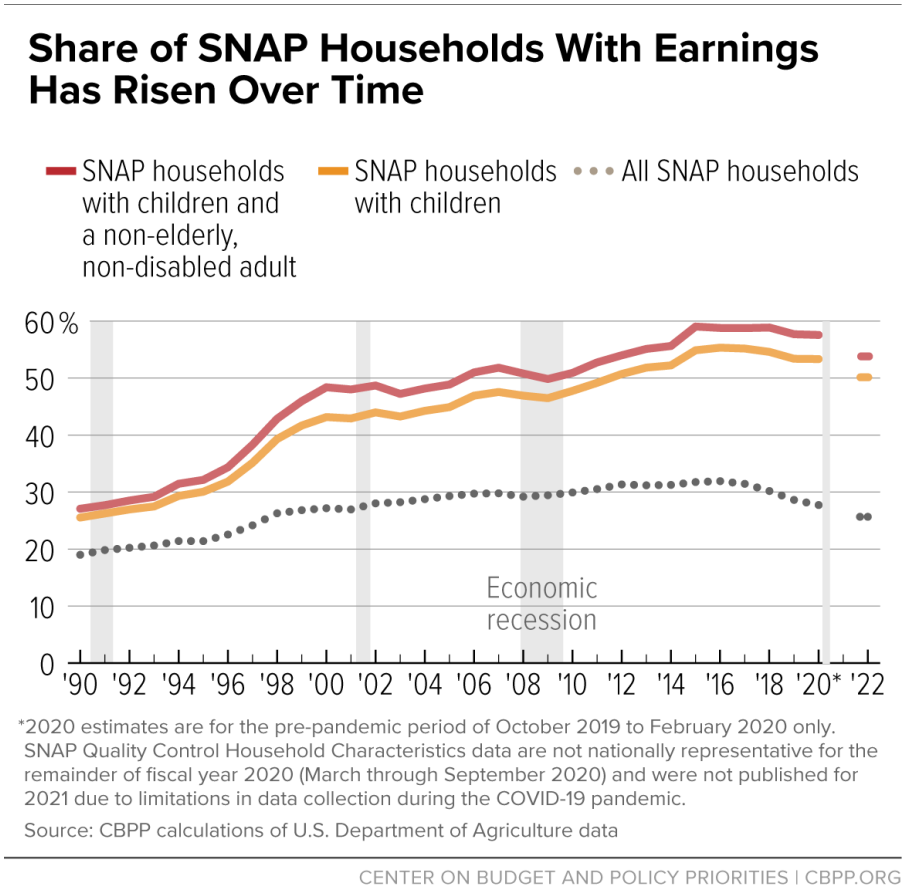
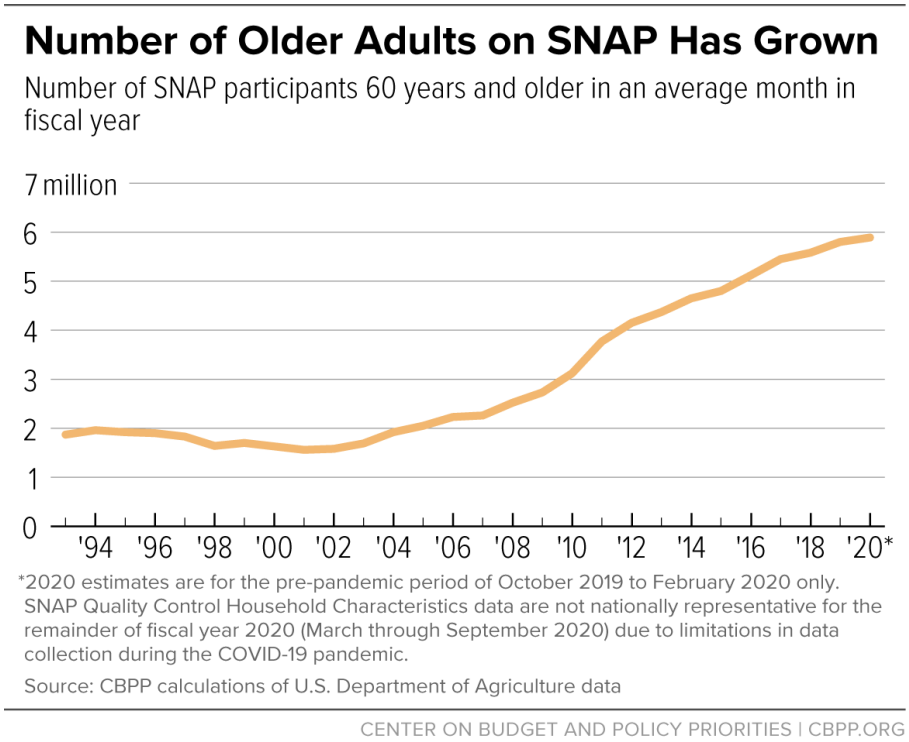


The share of SNAP households that work in an average month while receiving SNAP has grown over the past three decades. Work rates have risen among all SNAP households over time, but especially among households with children. This overall trend continued despite the large job losses during economic downturns such as the Great Recession. In more recent years, the share of households with earnings has declined, partly due to the increase in older adults' share of the SNAP caseload as the overall U.S. population ages.[30] Older adults are more likely to rely on fixed incomes and less likely to have earnings.



More older adults are participating in SNAP. The number of older adults receiving SNAP benefits has doubled since 2009, outpacing population growth for older adults in the general population.[31] Participation rates for older adults have increased but are still lower than for other age groups.

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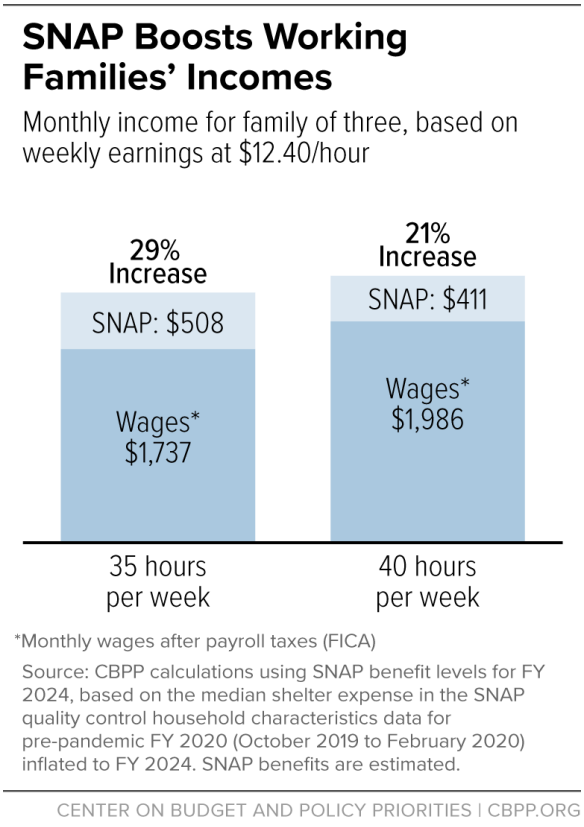

SNAP helps working families make ends meet. SNAP benefits have increased in recent years as a result of the 2021 Thrifty Food Plan revision and cost-of-living adjustments reflecting food inflation during the COVID-19 pandemic. For a family of three with one full-time worker who earns $12.40 an hour (the hourly wage for a household of three with an annual income at the federal poverty level in 2024), SNAP boosts the family's take-home income by roughly 21 to 29 percent, depending on the number of hours worked. For a mother with two children who works 35 hours a week, for example, adding her SNAP benefits increases her monthly income by 29 percent.

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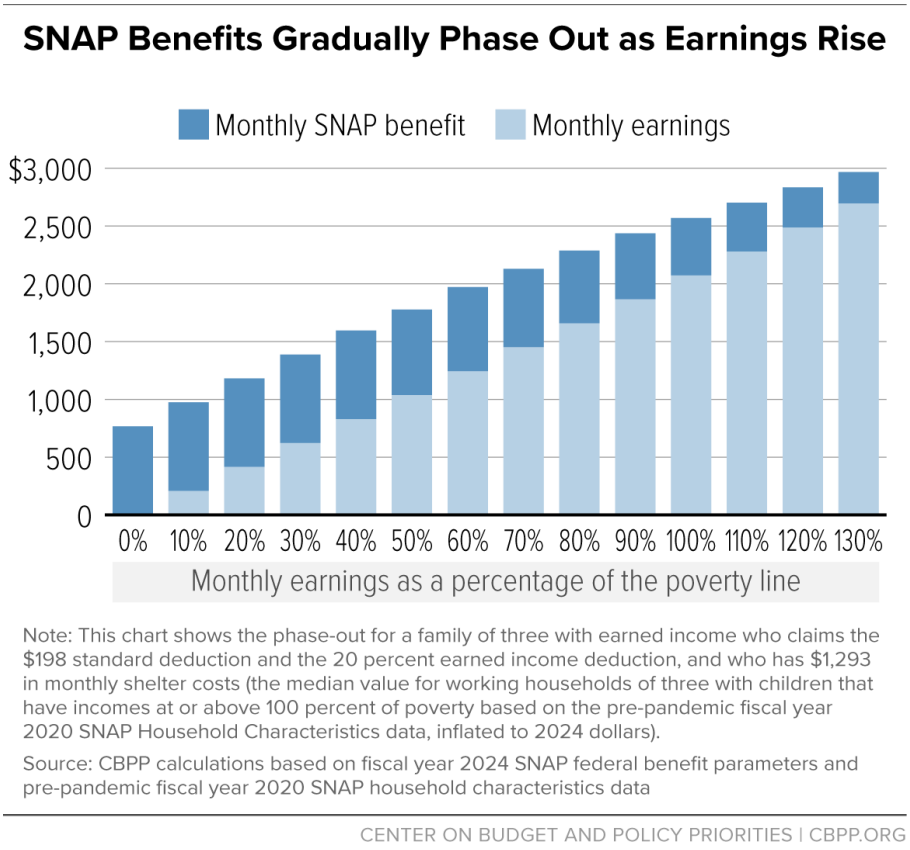

SNAP's benefit structure supports workers. The SNAP benefit formula is designed to support workers, phasing out benefits slowly as earnings rise. The benefit formula favors earned income over unearned income by enabling participants to take an earnings deduction equal to 20 percent of their earned income, which enables them to qualify for a larger SNAP benefit.

SNAP also provides crucial support for workers if they become unemployed: they can receive benefits quickly and on a monthly basis, unlike some other programs that have waiting lists or provide benefits annually.

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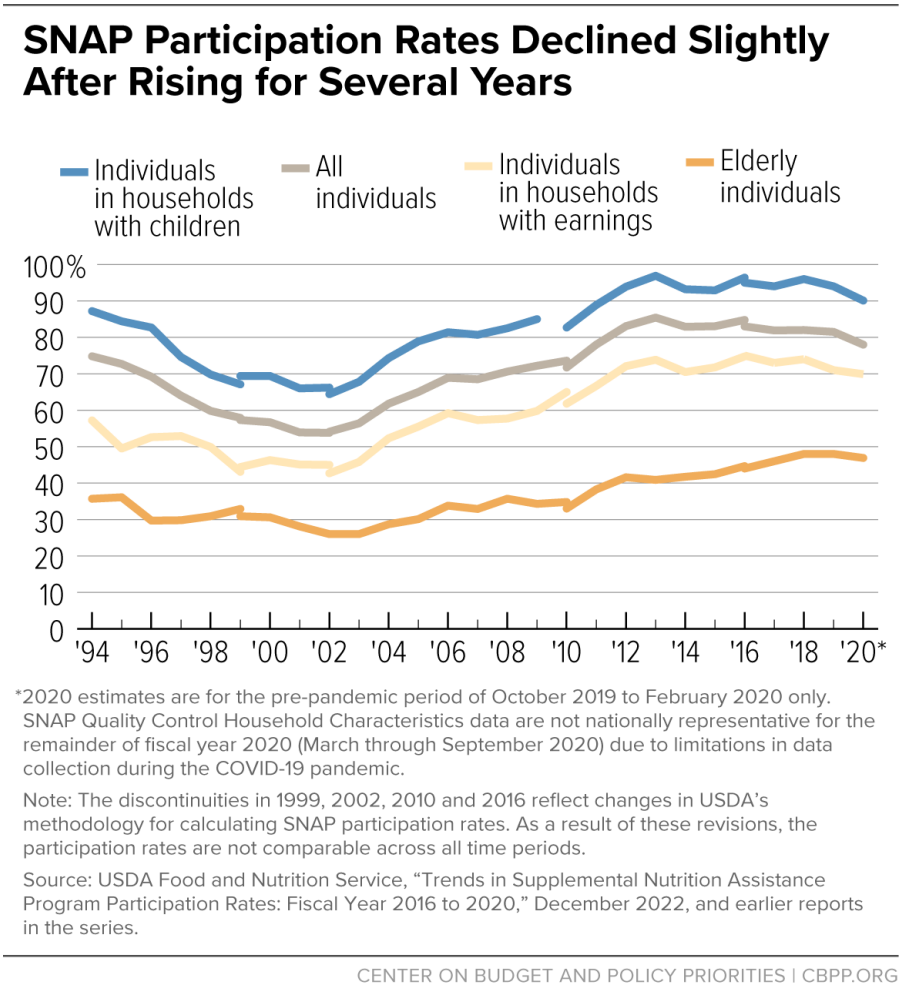
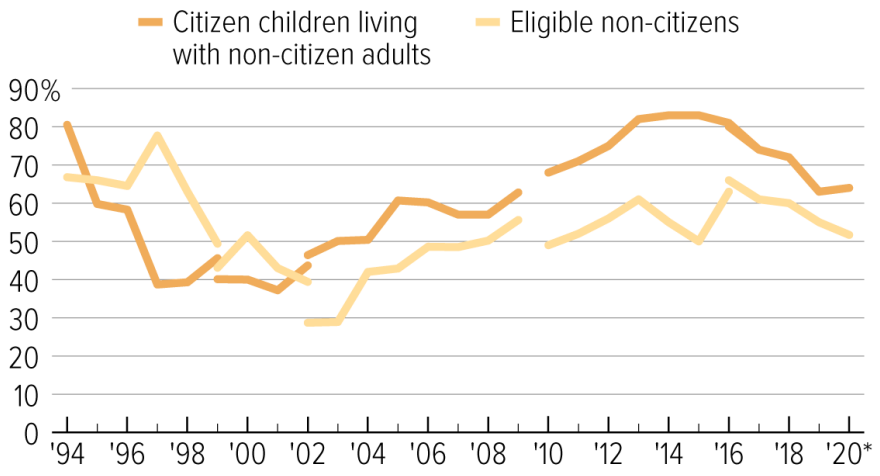
Part VIII: SNAP Reaches Most Eligible People, With Some Important Exceptions



SNAP participation rates have declined somewhat after generally rising over time. SNAP reached 82 percent of eligible individuals in a typical month in 2019, the most recent full year of data. That represents a significant improvement from 2001, when participation bottomed out at 54 percent. Among eligible individuals in working families, participation rose from 43 percent to 71 percent between 2002 and 2019. Participation rates among older adults are much lower but have risen over time as well, from 26 percent in 2002 to 48 percent in 2019.

SNAP Participation of Non-Citizens Declined After Rising for Several Years



*2020 represents the pre-pandemic months of October 2019 through February 2020 only.

2020 estimates are for the pre-pandemic period of October 2019 to February 2020 only. SNAP Quality Control Household Characteristics data are not nationally representative for the remainder of fiscal year 2020 (March through September 2020) due to limitations in data collection during the COVID-19 pandemic.

Source: USDA Food and Nutrition Service, "Trends in Supplemental Nutrition Assistance Program Participation Rates: Fiscal Year 2016 to 2020," December 2022, and earlier reports in the series.

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The general trend of participation increasing over time holds true for eligible non-citizens and children who are citizens who live with non-citizens, but declines have been steeper in recent years. People without a documented immigration status are ineligible for SNAP, but those with lawful immigration statuses, such as immigrant children, refugees, asylees, and qualified immigrant adults who have been in the U.S. for at least five years, are eligible. (Citizen children living with non-citizen adults are eligible on the same basis as other children.) Among eligible non-citizens, participation rates rose from 28 percent in 2002 to a peak of 66 percent in 2016, then declined to 55 percent in 2019.

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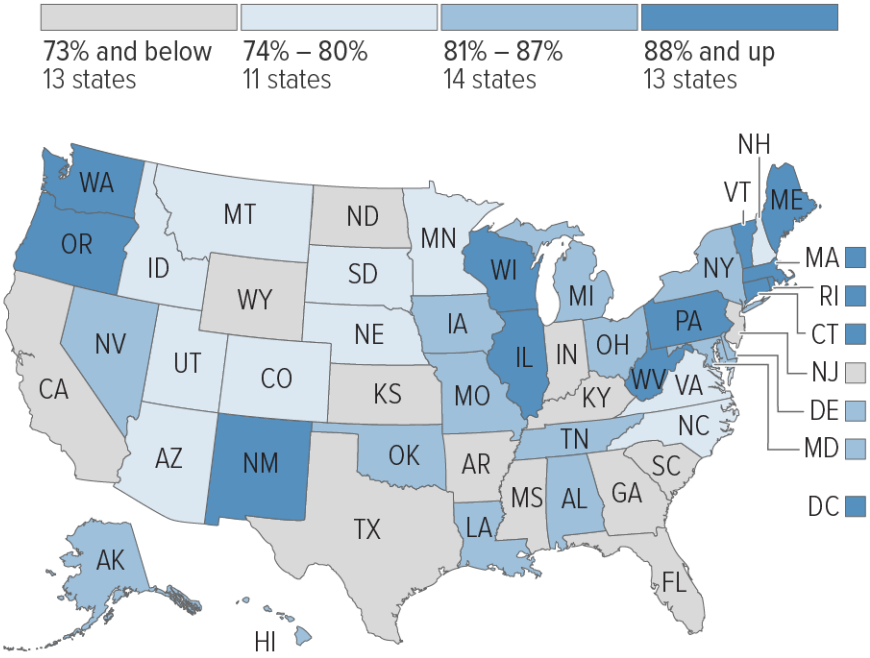
SNAP Participation Rates for Eligible Individuals by State, 2020 (pre-pandemic)



Notes: The 2020 rates are for the pre-pandemic period of October 2019 to February 2020 only. SNAP Quality Control Household Characteristics data are not nationally representative for the remainder of fiscal year 2020 (March through September 2020) due to limitations in data collection during the COVID-19 pandemic.

Source: Agriculture Department, "Reaching Those in Need: Estimates of State SNAP Participation Rates in 2020"

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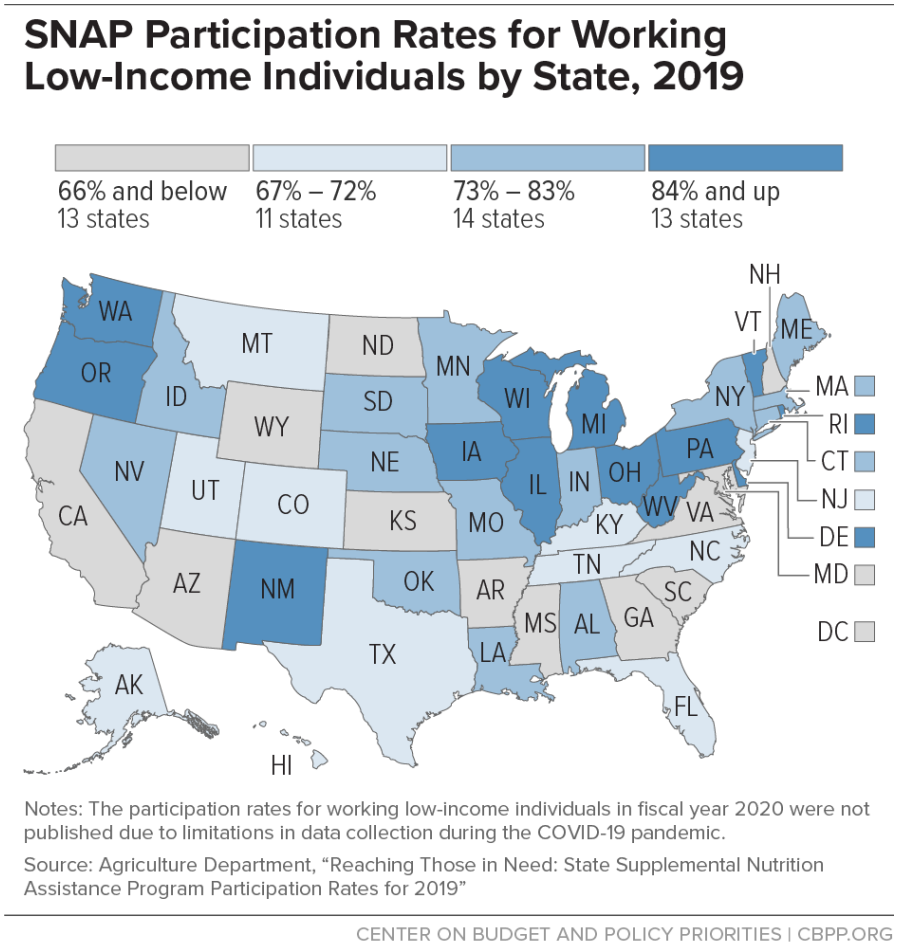
Participation rates vary widely by state. Some states serve a high percentage of eligible households, such as Illinois, Pennsylvania, Oregon, and Rhode Island. Others serve a relatively low percentage, such as Arkansas, Kentucky, Mississippi, and Wyoming. In every state except Wyoming, however, more than 50 percent of eligible individuals participate.[32]



Working families with low incomes are underserved in many states. SNAP provides an important support for working low-income individuals, but this population is often hard to reach. In 2019 (the most recent year of data available), 72 percent of eligible working low-income individuals participated. In all states except Indiana, working low-income individuals participated at a lower rate than all eligible individuals in the state.

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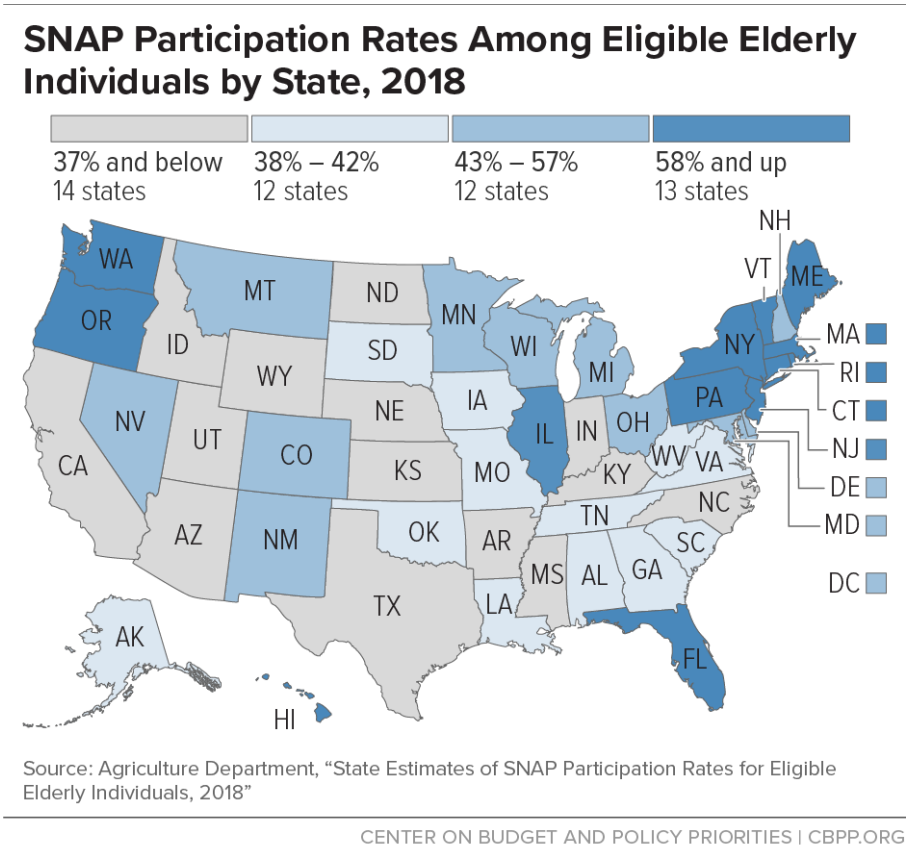
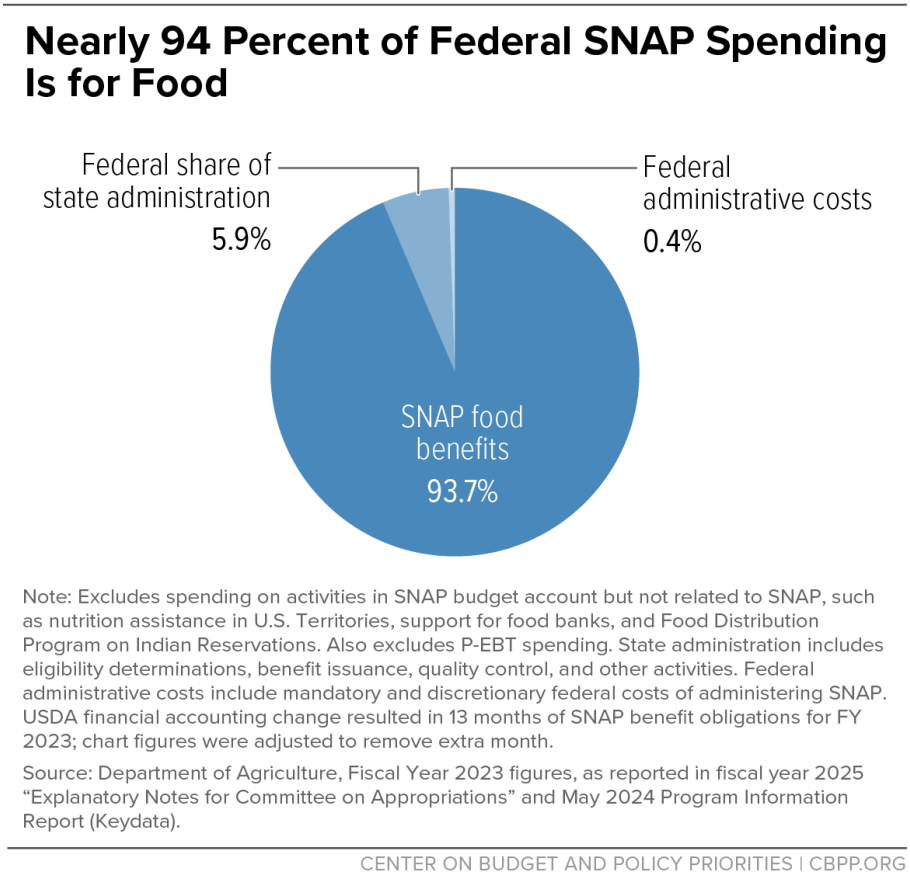


Older adults are underserved. Many low-income older adults who struggle to get by on low, fixed incomes and have critical unmet dietary needs don't participate in SNAP. Only 48 percent of eligible individuals over age 60 participated in 2019 nationwide, though participation rates had risen modestly in the 2000s and 2010s.[33]

Participation among eligible older adults varies widely across states. In 2018, the most recent year for which state-level estimates are available, state-level participation rates ranged from 22 percent to 78 percent.[34]

Part IX: SNAP Is Efficient



Nearly 94 percent of federal SNAP spending goes for benefits to purchase food. The rest goes toward administrative costs, including reviews to determine that applicants are eligible, monitoring of retailers that accept SNAP, and program integrity and anti-fraud activities.

The federal government spent about $115 billion on SNAP in fiscal year 2023, including pandemic-related SNAP benefits (but excluding pandemic-related school meal benefits known as Pandemic EBT). The SNAP budget also funds other food assistance programs, including the block grant for food assistance in Puerto Rico, American Samoa, and the Commonwealth of the Northern Mariana Islands, commodity purchases for the Emergency Food Assistance Program (which helps fund food pantries and soup kitchens), and commodities for the Food Distribution Program on Indian Reservations.

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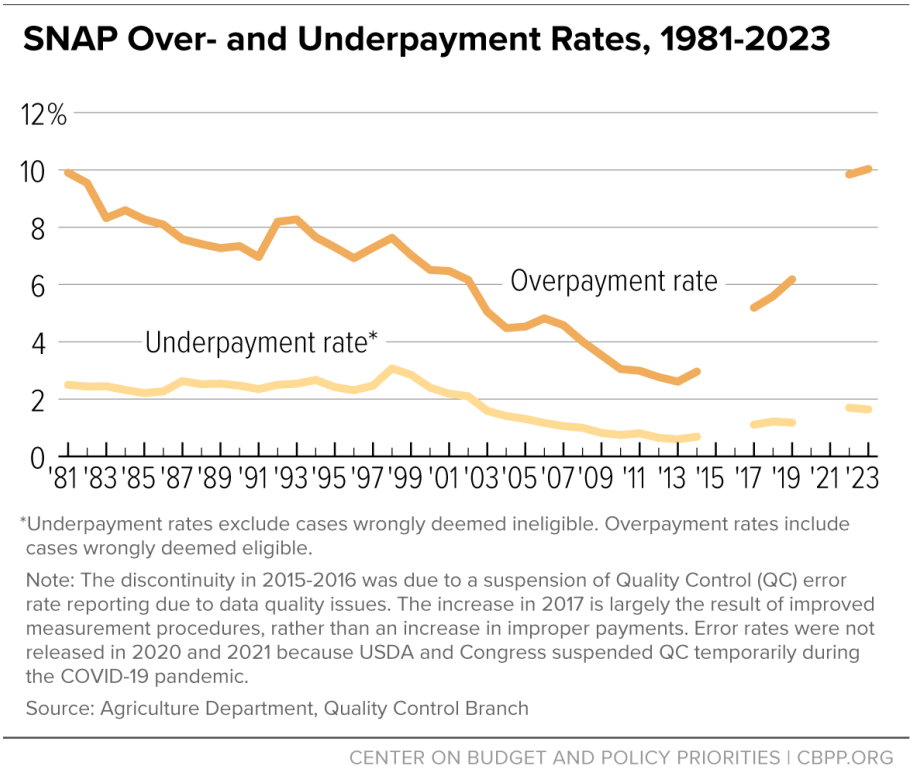


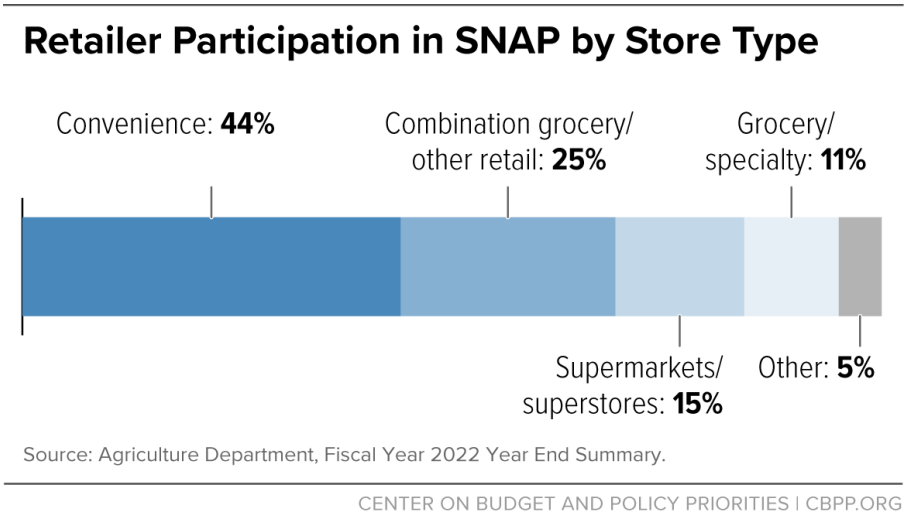
SNAP has an extensive quality control system. SNAP has one of the most rigorous payment error measurement systems of any public benefit program. Each year states pull a representative sample (totaling some 50,000 cases nationally) and thoroughly review the accuracy of their eligibility and benefit decisions. Federal officials re-review a subsample of the cases to ensure accuracy in the error rate they assign each state. States face financial penalties if their error rates are persistently above the national average.

A USDA Office of Inspector General report in 2015 drew attention to concerns about data quality issues with SNAP error rates in many states. As a result, USDA did not report national or state-level error rates for all states for 2015 or 2016; during this time USDA conducted detailed reviews in all states and took action to address the quality and consistency of the measure. The corrected SNAP error rates for 2017 and 2018 were higher, an increase USDA attributed to the improved measurement process.

Quality control requirements were suspended in 2020 and 2021 due to the pandemic, so error rates were not established for those years. Error rates in 2022 were well above earlier levels, reflecting the ongoing challenges of the pandemic. The national SNAP overpayment rate in 2023, the most recent year available, was 10.03 percent. The underpayment rate was 1.64 percent, though this does not include underpayments for households who were improperly denied benefits.

SNAP's pandemic-related administrative flexibilities were intended to help states process new applications and keep people connected to SNAP during a temporary time of severe economic challenges. They were successful at meeting that goal: SNAP participation rates rose, and food insecurity held steady in 2020 and 2021 despite the increase in need. However, these flexibilities, which were largely still in effect in 2022 and 2023, may also have contributed to higher error rates in some states.

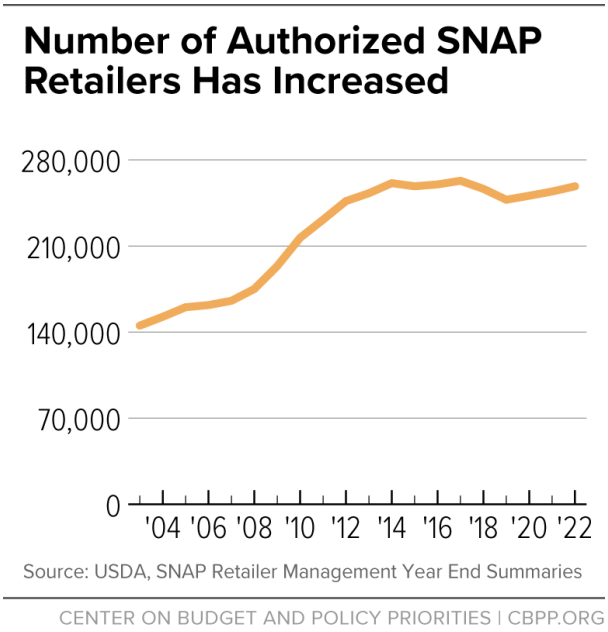
Part X: SNAP Is an Important Public-Private Partnership



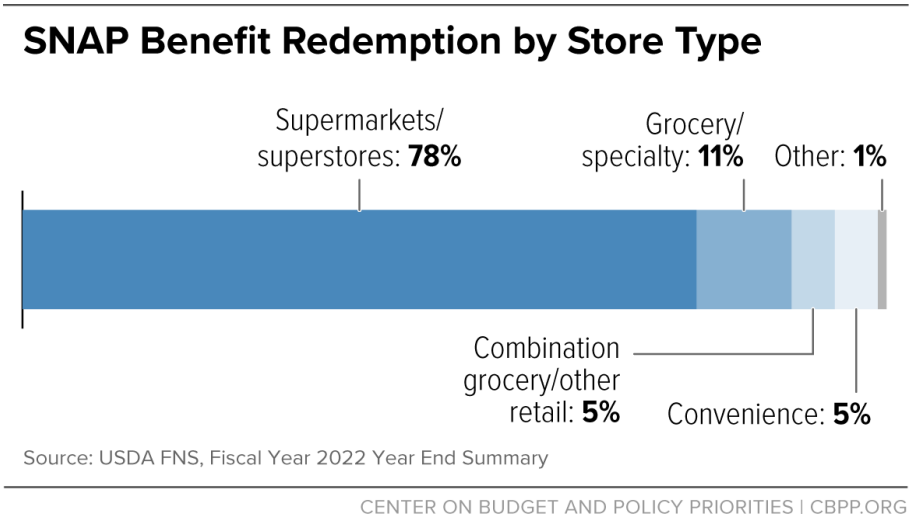
SNAP boosts local economies. Because most households redeem their monthly SNAP benefits quickly, SNAP is one of the most effective forms of economic stimulus during a downturn. A USDA study estimated that every dollar in new SNAP benefits spent during a slowing economy would increase the gross domestic product by $1.54; earlier studies estimated this effect to be as high as $1.80 during a recession. According to the USDA study, the increase in SNAP benefits during a slowing economy has the largest effects on spending for food and durable goods, and on income and jobs in industries such as manufacturing, trade, and transportation.[35]

Further evidence that SNAP provides important stimulus to local economies comes from a study indicating that SNAP benefit redemptions give a greater boost to employment during recessionary periods than during economic expansions. The impact on *rural* employment is especially strong: during the Great Recession, SNAP benefits boosted employment in non-metropolitan (rural) counties by one job per $10,000 in benefits redeemed, compared to 0.4 jobs in metropolitan (urban) counties. Furthermore, SNAP benefits did more to boost employment during the Great Recession than all other federal and state government transfer programs combined.[36]

Food stores can participate in SNAP if they stock a prescribed variety of foods and provide adequate information on the nature and scope of their business. This ensures that SNAP participants can redeem benefits in many of the stores and settings available to other consumers, though some geographic areas have few or no authorized retailers. Participating retailers include superstores (such as warehouse clubs and big-box retailers), supermarkets, grocery stores, corner stores, and farmers markets. Convenience stores were the largest single category in fiscal year 2022, representing 44 percent of all SNAP retailers. Stores that combine grocery and other retail store formats represented a quarter of all SNAP retailers. Farmers markets, commissaries, wholesalers, food co-operatives, and meal service facilities represented 5 percent.



The number of SNAP retailers has risen considerably. In 2022 some 258,000 retailers were authorized to accept SNAP benefits — 78 percent more than in 2003.



SNAP households spend most of their benefits at supermarkets and superstores. Participants redeemed 78 percent of their benefits at superstores and supermarkets in fiscal year 2022, even though these stores make up only 15 percent of all available retailers. Superstores alone redeemed 52 percent of all benefits.

While nearly half of SNAP retailers are convenience stores, they are a minor source of food for participants, redeeming only 5 percent of SNAP benefits.

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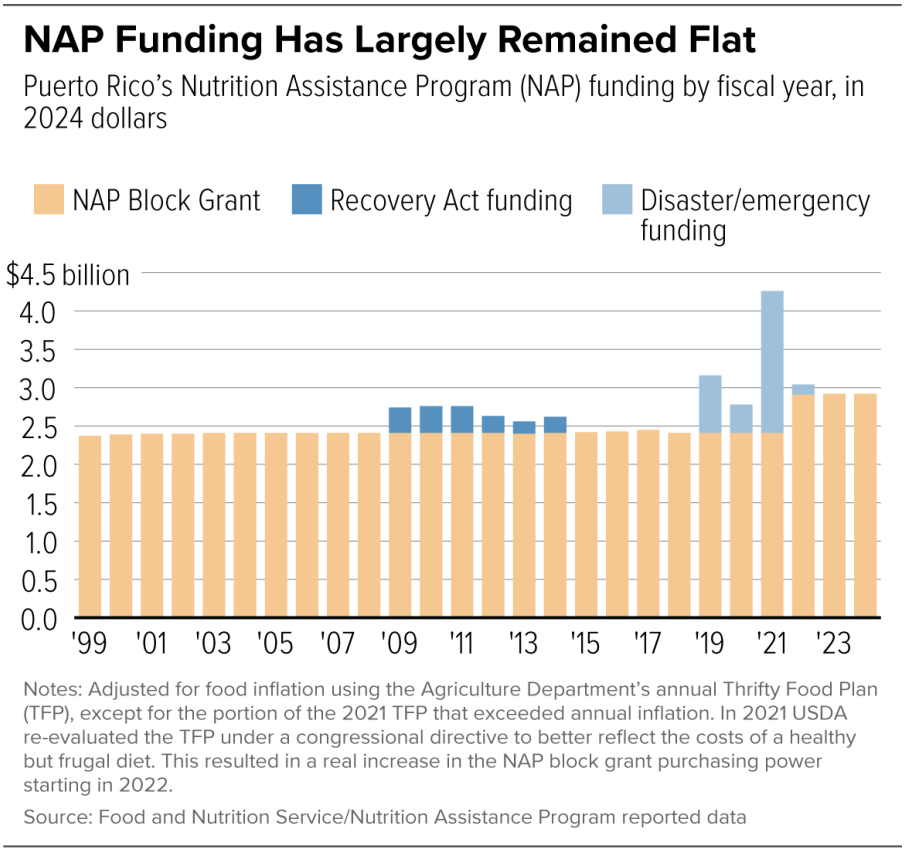
Part XI: Food Assistance in Puerto Rico



Puerto Rico's food assistance program has fixed funding, lower benefits. Puerto Rico faces chronically high poverty and low labor force participation, due in part to significant lingering effects from a number of crises over the past decades, including devastating hurricanes in 2017, bankruptcy, and the COVID-19 pandemic.[37] Nearly 42 percent of Puerto Rico's population lived in poverty in 2022, and its annual unemployment rate stood at 6 percent in 2023.[38]

Puerto Rico participated in SNAP's predecessor, the Food Stamp Program, until 1982, when Congress converted the territory's program into a capped block grant program.[39] As with SNAP, participants in Puerto Rico's program — called the Nutrition Assistance Program (NAP) — receive monthly benefits they can redeem using electronic debit cards at grocery stores. Eligibility for NAP is based on a household's size, income, and resources. Unlike SNAP, NAP is not an entitlement program; its annual funding is fixed regardless of changes in need, so NAP cannot respond easily to significant economic shifts or the aftermath of extreme weather.[40]

Base funding for NAP remained flat, after adjusting for food inflation, from the mid-1990s through 2021, although Congress authorized temporary funding increases in response to the Great Recession, destructive hurricanes in 2017, and the COVID-19 pandemic.[41] The 2021 Thrifty Food Plan revision resulted in a permanent 23 percent increase in NAP funding beginning in fiscal year 2022.[42] But even with the increase, NAP benefits are far less generous than they would have been if Puerto Rico participated in SNAP.[43] For the nearly 1.4 million individuals who received NAP benefits in an average month in fiscal year 2023, benefits averaged about $175 per person per

month, or about $1.90 per person per meal. The average household received roughly $307 per month.[44]

The U.S. Territories of American Samoa and the Commonwealth of the Northern Mariana Islands (CNMI) also receive capped block grants for nutrition assistance in lieu of participating in SNAP, despite having among the highest poverty rates in the country and being increasingly prone to devastating storms. Similar to Puerto Rico, American Samoa and the CNMI must constrain benefit levels and eligibility for their food assistance programs to stay within their block grant funding, rather than base them on need or the price of food.

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LIFE | HEALTH | FREEDOM

LIBERTANA®

Home and Community Based Alternatives

HCBA Intake Manager - Breya Hodge

HCBA Program Manager - Nicole Farshchian

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What is Libertana?

We provide services aimed at providing *Medi-Cal* clients the option to stay out of the of institutional settings (SNF/Hospital) and keeping them in the community for as long as our clients desire through a variety of services.

Discharge Planning

Referral to community resources

Case Management

Caregiving

Housing Placement

Home Health and more!

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Summary of HCBA

Home Community Based Alternatives (HCBA) is a Medi-Cal waiver that allows individuals to receive care at home when normally they would be institutionalized.

To be eligible for HCBA a beneficiary must have Full Scope Medi-Cal and meet acute, subacute, or Nursing Facility level of care. Many of our clients have diagnoses that leave them requiring Activities of daily living (ADL) and Instrumental activities of daily living (IADL) assistance.

The HCBA waiver can help with home adaptations, shift care costs, enabling family members to get compensation for providing care for their beneficiaries, and helping those who have been institutionally deemed become eligible for Medi-Cal!

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Eligibility/where do we serve

The HCBA waiver is available all throughout California but Libertana serves the following counties:

- **Alpine, Kern, Fresno, Kings, Tulare, Madera, Mariposa, Merced, Mono, Stanislaus, Tuolumne, Inyo, San Luis Obispo, Amador, Calaveras, Santa Clara, Santa Cruz, San Benito, San Mateo, Monterey, and sections of Los Angeles and Orange Counties.**

We are one of two HCBA providers in Orange County and Los Angeles. Agency designation is broken down by zip code, which can be found on DHCS's website.

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Eligibility

These services are available to clients of all ages.

- **Must have Medi-Cal.**
- **At a minimum, all eligible clients must have the following:**
  - **Safe housing in place**
  - **A primary and backup caregiver**
  - **Primary care physician**
  - **Meet level of care criteria**

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HCBA Services

HCBA aims to provide comprehensive case management for our clients to ensure they maintain medical stability in their lives and at home, covered by their Medi-Cal.

This program offers a vast number of benefits such as:

- **Home modification**
- **Personal Care Hours (Waiver Personal Care Services; WPCS)**
- **Personal Emergency Response Systems (PERS)**
- **Shift care LVN/CHHA**
- **Training /Education LVN/RN on caregiving**
- **Institutional deeming**
- **Congregate living health facilities (CLHFs)**
- **Case management**

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Home Mods/Assistive Tech

Equipment and disposable material we can assist with

Home Modifications

- This can include wheelchair lifts, widening hallways, bathroom modifications, ramp installations, shower bar installations, etc.
- Lifetime limit of $5000
- Other 1915b/c waivers and 1115 demonstrations offer this as well

Assistive technology

- includes tablets, Augmented communication devices, Emergency alert adaptations
- Limited to $2500 a calendar year

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Waiver Personal Care Services

- For *all* ages
- Requires an open IHSS Case
- Requires IHSS providers to work the hours
- Limitation on hours that can be worked
  - 66/week if they have more than 1 client
  - 70:45/week if only one client
  - Max 283/mo
- Overtime available

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Shift Care

For 21 and up

- CHHA
- LVN
- RN
- INP (independent nurse provider)

- U21 goes through CCS/EPSDT
  - the waiver can assist with identifying HHAs and navigating the CCS/EPSDT process through case management

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Institutional Deeming & Spousal Impoverishment

Medi-Cal Eligibility

- **Medicaid Waiver Institutional Deeming (ID) is a process to obtain full scope unrestricted Medi-Cal without a share of cost for developmentally disabled consumers under age 18.**
- **Through ID, the consumer's family income and resources are not taken into consideration; the consumer is assessed on their own merit. However, if the consumer has income and/or resources of their own (i.e., court appointed child support, trust fund income, etc.) this may result in ineligibility.**
- **When approved for Medi-Cal via Institutional Deeming our consumers will have access to all Medi-Cal services including medical, dental and Early and Periodic Screening Diagnosis and Treatment (EPSDT) supplemental services.**

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CLHF

Congregate Living Health Facility

- 24/7 Level of Care
- Sub-acute or Acute Care Needs
- Home style intimate setting with 6-18 beds

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Case Management

- Case Management is provided on a monthly basis by either an Registered Nurse or Social Worker
- Includes monthly safety assessment, assistance with referrals, assistance with navigating social service system
- Bi-annual plan of care assessments for services

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Case Study 1

Wiley Waites was referred to the HCBA waiver by a discharge social worker in the skilled nursing facility he is currently residing in. Wiley is 50 years old with paraplegia and requires moderate assistance with transferring, bathing, and getting dressed.

Wiley is also G-tube dependent. He does not have any family or friends to help care for him and lost his home due to his extended SNF stay. His SNF Social Worker identified a Congregate Living Health Facility (CLHF) that could accommodate for his level of care.

After Wiley completes an HCBA application and waits for an enrollment slot to be released..The Intake Social Worker then makes contact to gather additional Information, conduct a biopsychosocial assessment, and schedule the intake Assessment with a HCBA RN.

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Case Study 1

The assessment shows that he meets nursing facility level of care and confirmed the recommendation to transfer to a Congregate Living Health Facility (CLHF) services due to not having a home to discharge to.

After completing all necessary HCBA enrollment paperwork, the HCBA team submitted his packet to DHCS for approval. The intake social worker helps the SNF discharge social worker get the client ready to be discharged to the CHLF as they wait for approval.

Wiley is paired with an HCBA social worker and registered nurse for continuous open case management after receiving approval from DHCS. He can now reside at the Congregate Living Health Facility and receive round-the-clock care in a cozy home-based setting as he has been authorized for HCBA. Through clinical semi-annual exams and monthly social worker visits, our HCBA team continuously monitors his services, safety, and overall medical stability, which leaves him feeling supported.

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Case Study 2

Penny Goh is a 13 year old girl diagnosed with Cerebral Palsy and requires moderate to maximum assistance with her Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

Her mother is her main caregiver and had to leave her previous career in order to provide care for her daughter. Penny currently receives Respite services from Regional Center, but struggles with finding appropriate providers in their location.

Penny also receives In Home Supportive Services (IHSS) and her mother is her provider. In a Facebook group Penny's mother finds out about the HCBA waiver and how she could utilize personal care hours in tandem to IHSS so she submits an HCBA application.

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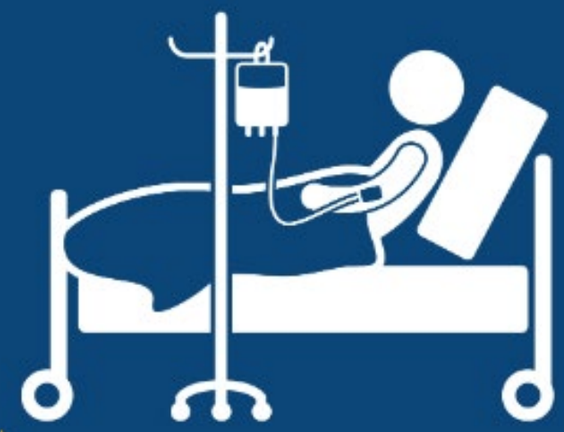
Case Study 2

Once the HCBA application is received, Penny is screened by an HCBA Registered Nurse to confirm she is eligible for HCBA then the intake process starts. Her packet is submitted to DHCS. Once it is approved, she is assigned to a HCBA Social Worker and Registered Nurse for ongoing case management to ensure safety and stability.

With the circle of support that comes with case management from Penny's HCBA team, her mother is at ease having more balance and relief regarding Penny's care.



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Start the process today!

Clients can self-refer by completing an application or have someone apply for the waiver on their behalf.

- **Clients who require additional help to live their lives to the fullest can benefit from this program. Children aging out of EPSDT/CCS, clients living in hospitals or skilled nursing facilities who need home health providers to return home, need access to medi-cal benefits, or clients utilizing IHSS and needing more support.**

If you or someone you know can benefit from these services, reach out to our central intake department to learn more and to start the process!

Contact us at info@libertana.com

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Thank

You!

To send a referral, reach out to:

Info@libertana.com

You can reach us at (818) 492-9265 or ext. 1581

www.Libertana.com

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CalOptima Health

Health Equity Updates

MAC/PAC

April 09, 2026

Michaell Silva Rose, DrPH, LCSW

Chief Health Equity Officer

Our Mission

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

Our Vision

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

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What is Health Equity?

The state in which everyone has a fair and just opportunity to attain their highest level of health.

- Optimal health outcomes for all
- Fair access to what people need to be healthy
- Removing avoidable health differences between groups
- People receive levels or types of support they need depending on their needs and circumstances

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So, What: Why Focus on Health Equity?

Fulfillment of our Mission and Vision

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

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

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Why Focus on Health Equity?

Health Equity efforts:

- **Improve Member Health**
- **Improve Member Experience**
- **Increase Member Retention**
- **Increase Cost Efficiency**

CalOptima Health

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2025: A Year of Opportunities

- Equity and Community Health shifted from direct member care support to organizational integration of health equity
  - Moved from a vertical to a horizontal health equity approach
  - Continued journey to add a health equity lens to all organizational efforts
  - Strategic planning and co-design of Health Equity Guiding Principles, Goals and Objectives

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2025 Health Equity Accomplishments

Initiative	Accomplishment
Updated CalOptima Health Vision	• Vision updated in 2025 to reflect our commitment to health equity and high-quality care
Health Equity Performance Goal	• Created an annual staff performance goal on leading with dignity, respect, and fostering an inclusive workspace
Health Equity Community Stakeholder Workgroup	• 2 sessions with **213** total attendees • Addressed state and federal legislation impacting Medi-Cal
Health Equity Guiding Principles	• Organizational alignment through **18** internal listening sessions and co-creation of Health Equity Principles
Optimal Health Outcomes Training	• **100%** staff completion across cultural competency and health equity fundamentals
Provider Trainings (CE/CME)	• **23** training sessions with **1,921** attendees • **25%** increase in sessions offered from 2024 • **111** Health Care Professionals received Maternal Health Training

Culture & Health Conversations	• **3** sessions with **264** participants
	• Focused on Cambodian, Vietnamese, Latino
	• Post survey results
	  ○ 98% improved understanding of health-related cultural needs
	  ○ 95% improved engagement strategies

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2025 Health Equity Accomplishments

Initiative	Accomplishment
Member Material Approvals	• **620** processed requests resulting in 34.2% increase over 2024 • **2,460** pages reviewed resulting in 47.6% increase over 2024 • Initiated Member Material Approval process redesign
NCQA Health Outcomes Accreditation	• Achieved with a **100%** score
Population Needs Assessment	• Analysis of **882,106 Medi-Cal members**, identifying trends and disparities • Analyzed **29+ HEDIS measures**, identifying those that met Minimum Performance Levels and those requiring improvement.
Member Population Health Needs Assessment (MPHNA) in Collaboration with Strategic Development	• Engaged **301 providers** • Surveyed **25,000+ members** • Conducted **13 focus groups** with targeted populations • Completed **22 stakeholder interviews** to deepen qualitative understanding
Community Facing Health Equity Asset Map	• Designed Health Equity Asset Map (launching 2026), enabling data-driven identification of community assets and resource gaps
Community Reinvestment Workgroup	• Internal and external stakeholders; quarterly meetings • Created CR plan and gained alignment

CalOptima Health

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2025 Health Equity Accomplishments

Initiative	Accomplishment
Hypertension Standing Orders Program	• **708** home BP monitors issued • **173** staff/providers trained • Provider office posters and video created
Blood Lead Screening Toolkit	• Co-designed with Kaiser and OC Health Care Agency • Blood lead screening (LCS) rates improving to **70.80%**, up from 63.89%
Community Impact Team (Pilot)	• **25** community events with **6,000** encounters • **65** community based partners • **1,200** members received health education • **1,648** health screening services completed
Birth Equity Initiative	• Expanded community partnerships; postpartum care rate for Black/African American members improved from 83.33% to **100%** • **19** Contracted Doulas providing services to **111** members
OC Health Care Agency – CHA/CHIP	• Co-lead Population Health Steering Committee. • Planning for joint Community Health Assessment (CHA) due in 2028. • Served on the Community Health Improvement Plan (CHIP) Steering Committee and six workgroups (Total of **71** meetings)
ECH and Quality: Flu Prevention Campaign	• Interactive Voice Response (**3,290** calls) • Social media (**3,242** followers) • Radio ads with an estimated reach of **100,000** listeners

CalOptima Health

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Advancing Health Equity Through Data-Driven Campaigns

- **Opportunity**: Low-performing quality measures often reflect care access disparities
- **Solution:** deploy multimodal campaigns that drive preventive care engagement
- **Approach for Health Equity**:
  - Use tailored, culturally responsive outreach strategies
  - Deliver multimodal engagement to members
  - Develop and deploy in collaboration with community partners

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CalOptima Health

2026 Health Equity Guiding Principles

Aligned with our mission to serve member health with excellence and dignity, respecting the value and needs of each individual, CalOptima Health's Health Equity Guiding Principles actively guide decision-making and reinforce our commitment to supporting all members having a fair and just opportunity to attain their highest level of health. In 2026, these principles will direct our priorities, shape our goals and drive measurable progress towards improving health outcomes for all members.

Learning Together

Provide business units with training and support to better understand health equity and integrate skills into their work that enhance member outcomes.

Provide Member-Centered Care

Promote and coordinate member-centered care delivered in alignment with members' needs and cultural preferences.

Engagement and Partnership

Partner with members, providers, community organizations and policymakers to co-design solutions.

Data-Driven Decisions

Enable staff to incorporate health equity into decision-making by using population-level data to identify trends, patterns, and differences in health outcomes, and to take action to improve outcomes.

CalOptima Health

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2026 Health Equity Goals

- Health Equity Guiding Principles influence how we approach our 2026 Health Equity Goals

1	2	3	4
Identify and **reduce health disparities** across populations by race, ethnicity, language, geography, disability status, age, and other social factors.	**Promote** equitable access to high-quality, culturally responsive **member-centered care**.	Identify and **address social and structural drivers of health** that impact outcomes and member experience.	**Embed health equity** into governance, accountability, and performance management across the organization.

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2026: Annual Health Equity Objectives

Health Equity Community Stakeholder Workgroup

Community Listening and Learning Sessions

Health Equity Data Identification and Review

Health Equity Business Partner Model

Coming 2027

CalOptima Health's 1st Community Resource Center

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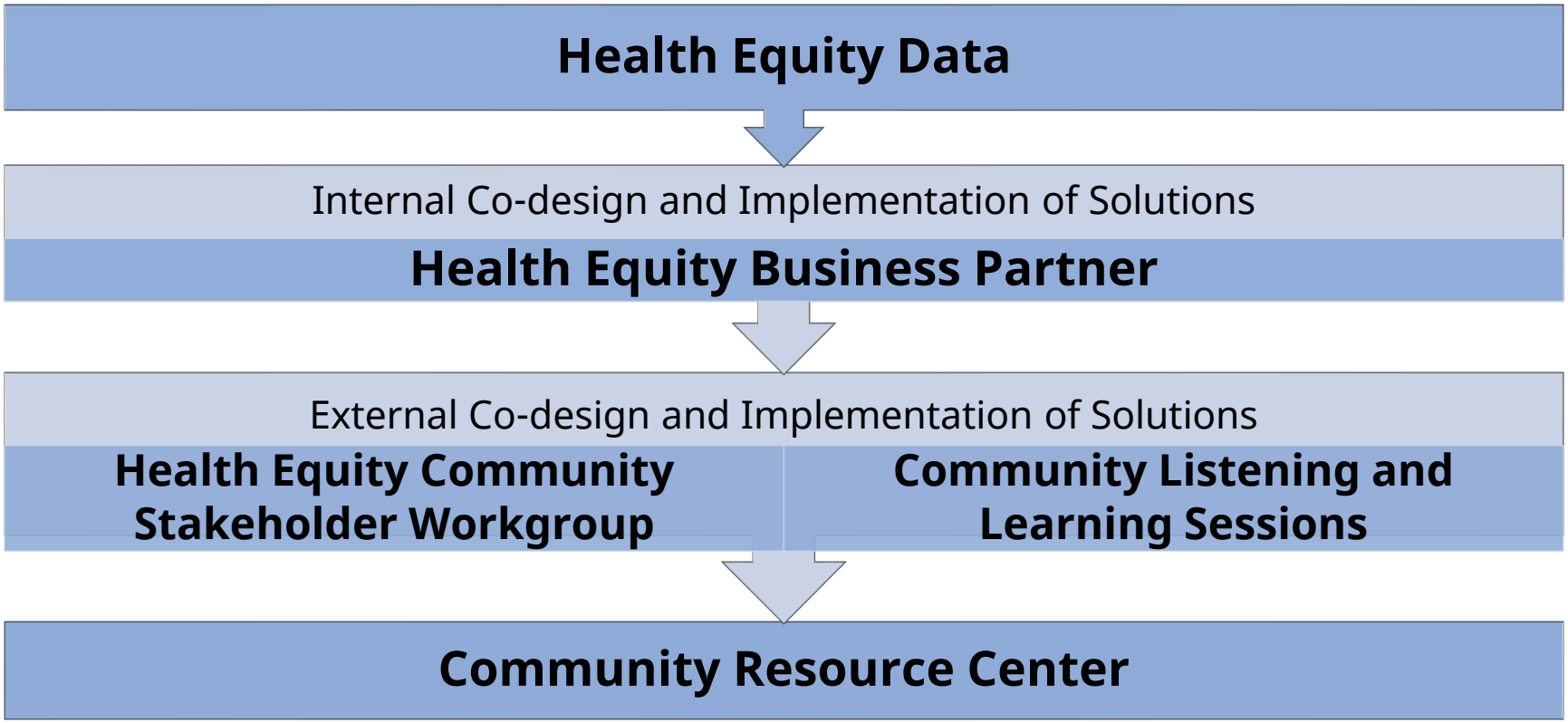
2026: Annual Health Equity Objectives

- Working together to advance health equity



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2025 Equity and Community Health Summary of Accomplishments

Overview

The 2025 Equity and Community Health Summary highlights CalOptima Health's progress in advancing health equity over the past year. Key initiatives and measurable outcomes demonstrate our commitment to ensuring all members have fair access to optimal health. By aligning organizational practices with our mission, **we continue to improve member retention, satisfaction, cost efficiency, and health outcomes.**

The following highlights the department's accomplishments in 2025, reflecting our ongoing dedication to embedding health equity across our policies, operations, and programs.

Members

We improved member health outcomes by expanding access to support services and implementing targeted programs that address disparities. These efforts lead to enhanced member satisfaction and better meet the needs of our diverse communities.

- Elevated Birth Equity outcomes, improving postpartum care for Black/African American members from **83.33% to 100%,** contracting **19 doulas serving 111 members**.
- Developed a Blood Lead Screening Toolkit that supported Lead Screening in Children (LCS) improvements to **70.80%, up from 63.89%** in 2023.
- Collaborated with Quality on a targeted flu prevention awareness campaign, reaching thousands of members via calls, social media, radio, and partnerships with Community-Based Organizations (CBOs).

CalOptima Health Staff

We invested in staff development, training and internal alignment to reinforce our member-focused approach, improve cultural competency, and promote health equity. These efforts lead to better health outcomes and cost savings.

- Updated CalOptima Health's organizational Vision to reinforce commitment to health equity and high-quality care.
- CalOptima Health advanced health equity by embedding it as a core pillar within the organizational strategic plan and aligning goals to support measurable and organization-wide equitable outcomes.
- Implemented health equity-focused annual performance goals for all staff, supporting a culture grounded in dignity, inclusion, and respect.
- Conducted **18** departmental listening sessions to co-create the Health Equity Guiding Principles and ensure enterprise-wide alignment.
- Partnered across departments to achieve **100%** score on the mandated National Committee of Quality Assurance (NCQA) Health Outcomes Accreditation (HOA).

Providers

Providers play a vital role in delivering member-centered care and advancing health equity. Through targeted training and ongoing support, we empower providers to deliver high-quality services and better address member needs.

- Issued **708** home blood pressure monitors and trained **173** staff/providers as part of the Hypertension Standing Orders Program.
- Sponsored **111** health care professionals to complete Maternal Mental Health training.
- Delivered **23** Continuing Education (CE) or Continuing Medical Education (CME) provider trainings with a total of **1,921** attendees, a 25% increase from 2024.

Community Partnerships and Engagement

Health equity initiatives rely on strategic, cross-sector partnerships with community organizations, educational institutions, hospitals, government agencies, policy makers, and community members. By engaging directly through outreach, collaboration, and ongoing community activities, we broadened our impact, co-designed solutions, and efficiently addressed health disparities.

- Co-led Orange County Community Health Assessment and Community Health Improvement Plan efforts with OC Health Care Agency and Kaiser Permanente, contributing to **71** collaborative meetings across six workgroups.
- Pilot Community Impact Team (CIT) delivered 25 community events, resulting in 6,000 health information encounters, with each encounter representing an individual interaction where health education was provided.
    - Additionally, CIT provided health screenings for **1,648** unique community members across social needs, mammography, blood pressure, and hypertension.
- Convened two Health Equity Community Stakeholder Workgroup sessions with **213** total attendees to educate and begin collectively addressing state budget and federal Medi-Cal policy changes.
- Hosted three Culture and Health Conversations with **264** participants, focusing on Cambodian, Vietnamese, and Latino member communities; 98% of participants reported improved understanding and learning.
- Partnered with Strategic Development and a vendor to conduct the Member Population Health Needs Assessment (MPHNA), engaging **301** providers, **25,000+** members, **13** focus groups, and **22** stakeholder interviews.
- Completed the Population Needs Assessment (PNA), a robust member population analysis, assessing **882,106** Medi-Cal members and over 29 Healthcare Effectiveness Data and Information Set (HEDIS) measures to identify quality trends, disparities and targeted improvement needs.
- Brought together stakeholders to develop the Community Reinvestment Program as mandated by DHCS, coordinating with local health agencies and communities to target investments that enhance health outcomes and reduce disparities.

Process Updates and Systems

We streamlined workflows, optimized data management, and strengthened cross-department coordination to advance health equity. These improvements have made our processes more efficient and responsive, resulting in clearer communication, better access, and more equitable care for members.

- Collaborated with a vendor in the creation of a community-facing **Health Equity Asset Map** to support community partners with data to drive decision-making and the co-design of health equitable solutions.
- Processed **620**-member material review requests (34.2% increase over 2024) and reviewed **2,460** pages of materials (47.6% increase), helping strengthen health literacy by promoting clear, accessible, and plain language communication.
- Achieved **100%** staff completion on state-mandated health equity and cultural competency training.

Looking Ahead: 2026 and Beyond

We will continue to embed health equity into policies, operations, and programs to **drive member retention, member satisfaction, cost efficiencies and improved health outcomes for all members:**

2026 Health Equity Guiding Principles

Learning Together

Provide business units with training and support to better understand health equity and integrate skills into their work that enhance member outcomes.

Provide Member-Centered Care

Promote and coordinate member-centered care delivered in alignment with members' needs and cultural preferences.

Engagement and Partnership

Partner with members, providers, community organizations and policymakers to co-design solutions.

Data-Driven Decisions

Enable staff to incorporate health equity into decision-making by using population-level data to identify trends, patterns, and differences in health outcomes, and to take action to improve outcomes.

2026 Health Equity Goals

1. Identify and **reduce health disparities** across populations by race, ethnicity, language, geography, disability status, age, and other social factors.
2. **Promote** equitable access to highly-quality, culturally responsive **member-centered care.**
3. Identify and **address social and structural drivers of health** that impact outcomes and member experience.
4. **Embed health equity** into governance, accountability, and performance management across the organization.

CalOptima Health

Government Affairs Update

Joint Meeting of the Member and Provider Advisory Committees

April 9, 2026

Donovan Higbee

Director, Public Policy

Our Mission

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

Our Vision

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

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Federal Update

- On February 3, President Trump signed into law *H.R. 7148: Consolidated Appropriations Act, 2026*
  - Nearly all remaining bipartisan Fiscal Year (FY) 2026 appropriations bills through September 30, 2026
  - 10-day extension of FY 2025 funding for the U.S. Department of Homeland Security through February 13
  - Pharmacy benefit manager (PBM) reforms
  - Health care extenders:
    - Community health centers: December 31, 2026
    - Medicaid disproportionate share hospitals: September 30, 2027
    - Medicare telehealth flexibilities: December 31, 2027
    - Hospital-at-home program: September 30, 2030

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Federal Update (cont.)

- On February 2, the U.S. Centers for Medicare & Medicaid Services (CMS) released a Final Rule on health care-related taxes, in alignment with H.R. 1
  - Tightens requirements for provider taxes to be generally redistributive in nature
  - Approves transition period for California's Managed Care Organization (MCO) Tax through December 31, 2026
  - After that time, the same MCO Tax structure will not be allowed, and the California Department of Health Care Services (DHCS) cannot fully implement Proposition 35
  - DHCS will update the 2026 spending plan and then work with stakeholders on the long-term future of the MCO Tax

CalOptima Health

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Federal Update (cont.)

- On March 3, the U.S. House Committee on Energy and Commerce sent a letter to Gov. Gavin Newsom on potential fraud, waste and abuse in Medi-Cal
  - Claims that Medi-Cal is vulnerable to unprecedented fraud like Minnesota and other states
  - The Committee will be examining Medi-Cal program integrity and actions taken by California
  - Written answers to ten questions, as well as associated documents, were requested by March 17
- CMS continues to release H.R. 1 guidance ahead of an Interim Final Rule on work requirements that must be issued by June 1

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State Update

- On January 9, Gov. Gavin Newsom released the FY 2026–27 Proposed State Budget
  - $2.9 billion shortfall due to increased program costs and federal funding loss, despite increased tax revenue
  - Medi-Cal is particularly affected as policy changes from H.R. 1 and last year's final state budget are implemented
    - 3.5% enrollment decrease is projected
  - No major new cuts were included, so most Medi-Cal initiatives (including CalAIM) continue to be fully funded
  - Revised budget proposal to be released by May 14

State Update (cont.)

- DHCS released its proposed CalAIM Section 1115 demonstration renewal application, effective January 1, 2027, through December 31, 2031
  - Continues Enhanced Care Management (ECM), Community Supports (CS) and justice-involved initiatives
    - Combines Recuperative Care and Short-Term Post-Hospitalization Housing (STPHH) into a single service and transitions it to In Lieu of Services (ILOS) authority like other CS
  - Adds new initiatives
    - BridgeCare Pilots: Targeted supports for older adults
    - Employment Supports: Helps members overcome work barriers to keep Medi-Cal coverage

State Update (cont.)

- Several H.R. 1 implementation/abatement bills were introduced before the February 20 deadline
  - SB 1202 (Weber Pierson): Would create a Medi-Cal application and enrollment dashboard; would strengthen beneficiary outreach regarding eligibility changes
  - AB 2161 (Bonta): Would automate verification for work requirements using available data sources; would prevent extending work requirements to state-funded Medi-Cal populations
  - AB 2201 (Boerner): Would align Medi-Cal renewal processes with new federal requirements; would encourage counties to verify income and assets through existing data sources
  - AB 2208 (Stefani): Would cap copays at $0.01 for applicable non-emergency services and prohibit service denial due to unpaid copays; would preserve three months of state-funded retroactive coverage

State Update (cont.)

- On February 19, CA State Assemblyman Avelino Valencia introduced Assembly Bill (AB) 2194 to improve the governance of CalOptima Health
  - Sponsored by the County of Orange
  - Two major provisions:
    1. Implements staggered terms for the seven Board seats with four-year terms (i.e., all seats except the two County Supervisors)
    2. Provides the alternate Board member with the same right of access to closed-session materials as other Board members
  - On March 24, the Assembly Health Committee passed and referred AB 2194 to the Assembly Appropriations Committee

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Q&A

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2025–26 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
SB 483 Stern	**Mental Health Diversion:** Would require that a court be satisfied that a recommended mental health treatment program is consistent with the underlying purpose of mental health diversion and meets the specialized treatment needs of the defendant. ***Potential CalOptima Health Impact*:** Increased oversight of behavioral health treatment for members.	**07/16/2025** Passed Assembly Public Safety Committee; referred to Assembly Appropriations Committee **06/04/2025** Passed Senate floor	CalOptima Health: Watch
SB 490 Umberg	**Alcohol and Drug Programs:** Would implement specific timelines for the California Department of Health Care Services (DHCS) to investigate unlicensed treatment facilities (i.e., sober living homes) that were unlawfully advertising or providing services. ***Potential CalOptima Health Impact*:** Increased oversight of treatment facilities that serve CalOptima Health members.	**01/26/2026** Passed Senate floor; referred to Assembly **01/05/2026** Gutted and amended **02/19/2025** Introduced	CalOptima Health: Watch
SB 626 Smallwood-Cuevas	**Maternal Mental Health Screenings and Treatment:** Would require a licensed health care practitioner who provides perinatal care for a patient to screen, diagnose and treat the patient for a maternal mental health condition. ***Potential CalOptima Health Impact:*** Increased access to behavioral health services for eligible members.	**08/28/2025** Passed Assembly floor; referred to Senate for concurrence in amendments **06/02/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 812 Allen	**Qualified Youth Drop-In Center Health Care Coverage:** Would require a health plan to provide coverage for mental health and substance use disorders (SUDs) at a qualified youth drop-in center, defined as a center providing behavioral or primary health and wellness services to youth 12 to 25 years of age with the capacity to provide services before and after school hours and that has been designated by or embedded with a local educational agency or institution of higher education. ***Potential CalOptima Health Impact*:** Increased access to behavioral health services for CalOptima Health Medi-Cal youth members.	**07/16/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/28/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Concerns
SB 874 Weber-Pierson	**Behavioral Health Treatment (BHT) Workgroup:** Would require certain individuals providing BHT services under Medi-Cal to complete background checks. Additionally, would require DHCS to convene a stakeholder workgroup to review the implementation of BHT services in Medi-Cal and release clinical guidance and treatment plan requirements. ***Potential CalOptima Health Impact:*** Enhanced oversight and quality of BHT services provided to members under 21 years of age with autism spectrum disorder and/or related conditions.	**02/11/2026** Introduced; referred to Senate Rules Committee	CalOptima Health: Watch
AB 37 Elhawary	**Behavioral Health Workforce:** Would require the California Workforce Development Board to study how to expand the workforce of mental health service providers providing services to homeless persons. ***Potential CalOptima Health Impact*:** Increased access to behavioral health services for members experiencing homelessness.	**01/16/2026** Died in Assembly Business and Professions Committee **03/13/2025** Referred to Assembly Labor and Employment Committee	CalOptima Health: Watch
AB 348 Krell	**Full-Service Partnership:** Establishes presumptive eligibility for Full-Service Partnership programs contingent upon meeting criteria and receiving recommendation for enrollment by a licensed behavioral health clinician. ***Potential CalOptima Health Impact*:** Increased continuity of care for members with serious mental illness.	**10/13/2025** Signed into law	CalOptima Health: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 384 Connolly	**Inpatient Prior Admission Authorization:** Would prohibit a health plan from requiring prior authorization for admission to medically necessary 24-hour care in inpatient settings, including general acute care hospitals and psychiatric hospitals, for mental health and SUDs as well as for any medically necessary services provided to a beneficiary while admitted for that care. ***Potential CalOptima Health Impact*:** Modified utilization management (UM) procedures for covered Medi-Cal benefits.	**01/23/2026** Died in Assembly Appropriations Committee **04/22/2025** Passed Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 423 Davies	**Disclosures for Alcoholism, Drug Abuse Recovery or Treatment Programs and Facilities:** Would mandate a business-operated recovery residence to register its location with DHCS. ***Potential CalOptima Health Impact*:** Increased oversight for members who have received SUD treatment.	**01/16/2026** Died in Assembly Health Committee **02/18/2025** Referred to Assembly Health Committee	CalOptima Health: Watch
AB 618 Krell	**Behavioral Health Data Sharing:** Would require each Medi-Cal managed care plan (MCP), county specialty mental health plan (MHP) and Drug Medi-Cal program to electronically share data for its members to support coordination of behavioral health services. Would also require DHCS to determine minimum data elements and the frequency and format of data sharing through a stakeholder process and guidance, with final guidance to be published by January 1, 2027. ***Potential CalOptima Health Impact*:** Increased coordination between Medi-Cal delivery systems regarding behavioral health services.	**07/07/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/03/2025** Passed Assembly floor	**05/07/2025** CalOptima Health: SUPPORT LHPC: Sponsor
AB 877 Dixon	**Nonmedical SUD Treatment:** Would require DHCS and the California Department of Managed Health Care (DMHC) to send a letter to the chief financial officer of every health plan (including a Medi-Cal MCP) that provides SUD coverage in residential facilities. The letter must inform the plan that SUD treatment in licensed or unlicensed facilities is almost exclusively nonmedical, with rare exceptions, including for billing purposes. These provisions would be repealed on January 1, 2027. ***Potential CalOptima Health Impact*:** Enhanced transparency and clarity around nonmedical treatment provided for SUDs.	**01/16/2026** Died in Assembly Health Committee **03/03/2025** Referred to Assembly Health Committee	CalOptima Health: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 951 Ta	**Autism Diagnosis:** Prohibits a health plan from requiring an enrollee previously diagnosed with pervasive developmental disorder or autism to receive a diagnosis to maintain coverage for behavioral health treatment for their condition. ***Potential CalOptima Health Impact*:** Increased access to care for specific behavioral health treatments.	**07/30/2025** Signed into law	CalOptima Health: Watch
AB 1970 Harabedian	**Mental Health and SUD Utilization Management:** Would prohibit a health plan from imposing step therapy as a prerequisite to authorizing coverage of any prescription drug used for the treatment of a mental illness or SUD. ***Potential CalOptima Health Impact:*** Expanded covered benefits for members.	**02/13/2026** Introduced; referred to Assembly Health Committee	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

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 7148 Cole (OK)	**Consolidated Appropriations Act, 2026:** Would provide FY 2026 appropriations for several federal departments and agencies, including the U.S. Department of Health and Human Services, as well as extend several expiring health care programs and increase health care oversight. Specifically, the bill would strengthen compliance among pharmacy benefit managers (PBMs), extend Medicare telehealth flexibilities through December 31, 2027, extend the hospital-at-home waiver for five years, and delay Medicaid disproportionate share hospital (DSH) cuts until FY 2028. ***Potential CalOptima Health Impact:*** Continued access to Medicare telehealth flexibilities for dual-eligible CalOptima Health members and delayed cuts to certain contracted hospitals.	**01/22/2026** Passed House floor; referred to Senate floor	CalOptima Health: Watch
SB 101 Wiener **AB 102** Gabriel	**Budget Act of 2025:** Makes appropriations for the government of the State of California for FY 2025–26. Total spending is $321 billion, of which $228.4 billion is from the General Fund. ***Potential CalOptima Health Impact:*** An overview of the FY 2025–26 Enacted State Budget is enclosed.	**06/30/2025** Signed into law	CalOptima Health: Watch
SB 106 Laird	**Budget Act of 2025:** Amends the Budget Act of 2025 by appropriating $90 million to Planned Parenthood in response to H.R. 1 cuts. ***Potential CalOptima Health Impact:*** Continued funding for certain family planning services.	**02/11/2026** Signed into law	CalOptima Health: Watch
SB 879 Laird **AB 1563** Gabriel	**Budget Act of 2026:** Would make appropriations for the government of the State of California for FY 2026-27 in alignment with the governor's proposed budget released on January 9, 2026. Total spending would be $348.9 billion, of which $248.3 billion would be from the General Fund. ***Potential CalOptima Health Impact:*** No major impacts to existing Medi-Cal and CalAIM services.	**01/09/2026** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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 I:** 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 Program of All-Inclusive Care for the Elderly (PACE) provider sanctions, effective immediately ***Potential CalOptima Health Impact:*** An overview of the FY 2025–26 Enacted State Budget is enclosed.	**06/30/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 144 Committee on Budget	**Health Omnibus Trailer Bill II:** Consolidates and enacts certain budget trailer bill language containing policy changes needed to implement health-related budget expenditures. Specifically, this bill: • Establishes the list of immunizations by the Advisory Committee on Immunization Practices (ACIP) • Exempts foster youth and former foster youth with Unsatisfactory Immigration Status from various service limitations in the Medi-Cal program (including enrollment freeze and monthly premiums) • Requires DHCS to convene a workgroup to discuss the implementation of the Children and Youth Behavioral Health Initiative (CYBHI) school fee schedule • Establishes the Abortion Access Fund to provide family planning services through grants and contracts • Requires Covered California to provide payments to qualified health plans to defray the costs of state-mandated gender-affirming care benefits ***Potential CalOptima Health Impact:*** An overview of the FY 2025–26 Enacted State Budget is enclosed.	**09/17/2025** Signed into law	CalOptima Health: Watch
RN 26 08635 Trailer Bill Language	**Skilled Nursing Facility (SNF) Financing Extension:** Would extend the SNF Quality Assurance Fee (QAF) and Medi-Cal Long-Term Care (LTC) Reimbursement Act from December 31, 2026, to December 31, 2027. ***Potential CalOptima Health Impact:*** Maintained funding for contracted SNFs.	**02/02/2026** Published by the California Department of Finance	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
RN 26 08913 Trailer Bill Language	**Aligning Evidence-Based Standards for SUD Treatment:** Would amend licensure and certification statutes for SUD treatment facilities, including Narcotic Treatment Programs (NTPs), to replace references to "detoxification" with the modern, industry-standard term "withdrawal management." Would also align state standards for SUD treatment facilities licensed or certified by DHCS with current, evidence-based standards of care by eliminating withdrawal management as a standalone service and integrating it into standard residential treatment, effective June 30, 2027. ***Potential CalOptima Health Impact:*** Improved coordination of SUD treatment services across the continuum of care.	**02/11/2026** Published by the California Department of Finance	CalOptima Health: Watch
TBD Trailer Bill Language	**H.R. 1**: Would implement Medi-Cal policy changes in compliance with the Medicaid provisions of H.R. 1, including but not limited to the following: • Reducing duplicate enrollments • Semi-annual eligibility redeterminations • Amending the definition of Qualified Non-Citizens • Reducing retroactive coverage • Community engagement requirements ***Potential CalOptima Health Impact:*** An overview of H.R. 1 is enclosed.	**02/02/2026** Published by the California Department of Finance	CalOptima Health: Watch
TBD Trailer Bill Language	**Menopause Coverage**: Would add menopause treatments as a Medi-Cal covered benefit, including hormone-replacement therapy, antidepressants, anticonvulsants, bioidentical hormones, and medications to address osteoporosis and vasomotor-related symptoms. ***Potential CalOptima Health Impact:*** New covered benefits for members experiencing menopause.	**02/02/2026** Published by the California Department of Finance	CalOptima Health: Watch
TBD Trailer Bill Language	**Community-Based Mobile Crisis Response Services:** Would make community-based mobile crisis response services an optional benefit in counties that agree to participate and provide the necessary nonfederal share of funding from local sources. ***Potential CalOptima Health Impact:*** Depending on future actions by the County of Orange, either maintained or decreased access to mobile crisis response services.	**02/12/2026** Published by the California Department of Finance	CalOptima Health: Watch

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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
AB 2138 Krell	**ECM Peer Support Specialists:** Would require ECM providers to include at least one peer support specialist in their interdisciplinary teams; specialists would have lived experience with recovery from mental illness and/or substance use. Additionally, would outline conditions where peer support specialists cannot be disqualified based on criminal background, fingerprint-based background check or similar screening that is a condition of employment, contracting, certification, credentialing, enrollment or participation in providing peer support services. ***Potential CalOptima Health Impact*:** Expanded access to peer support specialists for certain high-need members.	**02/18/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2348 Bonta	**Community Supports Extension:** Would extend Community Supports within the Medi-Cal managed care program — by proposing that the supports are deemed cost-effective and medically appropriate services — beyond the existing CalAIM initiative, beginning January 1, 2027. Additionally, would implement quarterly public reporting on Community Supports utilization with ongoing technical assistance. ***Potential CalOptima Health Impact*:** Safeguards access to Community Supports for Medi-Cal members.	**02/19/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: 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
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

Bill Number Author	Bill Summary	Bill Status	Position/Notes
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
SB 912 Cervantes	**Comprehensive Perinatal Services:** Would require DHCS to oversee a statewide community-based perinatal services program and enroll providers to deliver such services, but would maintain the role of the California Department of Public Health (CDPH) in regards to contracts, grants and agreements. ***Potential CalOptima Health Impact:*** Enhanced access to and delivery of perinatal services for pregnant and postpartum members.	**02/26/2026** Introduced; referred to Senate Health Committee	CalOptima Health: Watch
SB 944 Wiener	**Acupuncture Coverage:** Would remove the limitation requiring federal matching funds for acupuncture to be a covered benefit, preserving it as a covered benefit under Medi-Cal. ***Potential CalOptima Health Impact:*** Maintained covered benefits for members.	**02/11/2026** Introduced; referred to Senate Health Committee	CalOptima Health: Watch
AB 242 Boerner	**Genetic Disease Screening:** Would expand statewide newborn screenings to include Duchenne muscular dystrophy by January 1, 2027. ***Potential CalOptima Health Impact:*** Expanded covered benefits for members.	**01/23/2026** Died in Assembly Appropriations Committee **04/01/2025** Passed Assembly Health Committee	CalOptima Health: Watch
AB 298 Bonta	**Cost-Sharing Under Age 21:** Effective January 1, 2026, would prohibit a health plan from imposing a deductible, coinsurance, copayment, or other cost-sharing requirement for in-network health care services provided to an individual under 21 years of age, with certain exceptions for high deductible health plans that are combined with a health savings account. ***Potential CalOptima Health Impact:*** Increased costs for CalOptima Health; decreased costs for future members enrolled in Covered California line of business under 21 years of age.	**01/23/2026** Died in Assembly Appropriations Committee **01/13/2026** Passed Assembly Health Committee **02/10/2025** Referred to Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose

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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 appropriation by the Legislature: • Children greater than three years of age diagnosed with a condition that contributes to incontinence • Other individuals under 21 years of age to address a condition pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standards ***Potential CalOptima Health Impact:*** New covered benefit for pediatric members.	**01/23/2026** Died in Assembly Appropriations Committee **04/01/2025** Passed Assembly Health Committee	CalOptima Health: Watch
AB 1949 Lee	**Acupuncture Treatment Flexibility:** Would state the intent of the Legislature to enact legislation that allows more flexibility in Medi-Cal coverage for acupuncture treatments. ***Potential CalOptima Health Impact:*** Expanded covered benefit for members.	**02/13/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2160 Celeste Rodriguez	**Lactation Services:** Would require DHCS to update Medi-Cal's coverage guidance on lactation services by July 1, 2027, to clarify coverage policies for various lactation services, including health education, support and consultation. ***Potential CalOptima Health Impact:*** Expanded access to lactation services for members.	**02/18/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch
AB 2208 Stefani	**Federally Mandated Copayments:** In accordance with the minimum requirements of H.R.1, would set copayments at $0.01 for nonemergency services delivered to Medicaid Expansion adults with incomes between 100% and 138% of the federal poverty level, no later than October 1, 2028. Would exempt emergency and family planning services from copayments and prohibit service denial due to unpaid copayments. In addition, would allow self-attestation for Medi-Cal eligibility, including related to work or community engagement activities. ***Potential CalOptima Health Impact:*** Minimized financial burden on Medi-Cal members; decreased member burden to enroll in or maintain Medi-Cal coverage; minimized loss of members due to H.R. 1.	**02/19/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch
AB 2240 Stefani	**Private Duty Nursing for Specialty Care:** Would redefine private duty nursing for children under 21 as specialty care, covered by Medi-Cal, ensuring continuity and specialized health care for younger patients within home settings. ***Potential CalOptima Health Impact:*** Expanded access to care for youth Medi-Cal members.	**02/19/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch
Medi-Cal Eligibility and Enrollment			
SB 1202 Weber Pierson	**Eligibility Dashboard and Outreach:** Would mandate the development of a data dashboard to track Medi-Cal application and enrollment data, reflecting changes in federal Medicaid law. Would also require outreach to Medi-Cal beneficiaries about community engagement requirements and changes to eligibility while aligning cultural and linguistic standards. ***Potential CalOptima Health Impact:*** Improved visibility of eligibility and enrollment data for members.	**02/20/2026** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 1422 Durazo	**Medi-Cal Eligibility:** Would repeal the Medi-Cal enrollment freeze for individuals who are 19 years of age or older without satisfactory immigration status, which was included in the FY 2025–26 Enacted State Budget and became effective on January 1, 2026. Certain limitations would be maintained, such as the elimination of dental benefits and the implementation of $30 monthly premium payments. ***Potential CalOptima Health Impact:*** Expanded Medi-Cal eligibility for individuals with unsatisfactory immigration status; increased number of members.	**02/20/2026** Introduced	CalOptima Health: Watch
SB 1907 Addis	**Aligned Covered California Enrollment:** Would authorize Covered California to enroll an individual in the plan in which other members of the individual's household are enrolled, or the lowest cost plan available. ***Potential CalOptima Health Impact:*** Increased enrollment in future Covered California line of business; streamlined enrollment process for certain members.	**02/12/2026** Introduced; referred to Senate Health Committee	CalOptima Health: Watch
AB 315 Bonta	**Home and Community-Based Alternatives (HCBA) Waiver:** Would remove the cap on the number of HCBA Waiver slots and instead require DHCS to enroll all eligible individuals who apply for HCBA Waiver services. By March 1, 2026, would require DHCS to seek any necessary waiver amendments to ensure there is sufficient capacity to enroll all individuals currently on a waiting list. Would also require DHCS by March 1, 2026, to submit a rate study to the Legislature addressing the sustainability, quality and transparency of rates for the HCBA Waiver. ***Potential CalOptima Health Impact*:** Expanded member access to HCBA Waiver services.	**01/23/2026** Died in Assembly Appropriations Committee **03/25/2025** Passed Assembly Health Committee	CalOptima Health: Watch
AB 974 Patterson	**Managed Care Enrollment Exemption:** Would exempt any dual-eligible and non-dual-eligible beneficiaries who receive services from a regional center and who use the Medi-Cal fee-for-service (FFS) delivery system as a secondary form of health care coverage from mandatory enrollment in a Medi-Cal MCP. ***Potential CalOptima Health Impact:*** Decreased number of members.	**01/23/2026** Died in Assembly Appropriation Committee **04/22/2025** Passed Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1012 Essayli	**Unsatisfactory Immigration Status:** Would make an individual who does not have satisfactory immigrant status ineligible for Medi-Cal benefits. In addition, would transfer funds previously appropriated for such eligibility to a newly created Serving our Seniors Fund to restore and maintain payments for Medicare Part B premiums for eligible individuals. ***Potential CalOptima Health Impact:*** Decreased number of members.	**01/31/2026** Died at Assembly desk **02/21/2025** Introduced	CalOptima Health: Watch
AB 1161 Harabedian	**State of Emergency Continuous Eligibility:** Would require DHCS and the California Department of Social Services to provide continuous eligibility for its applicable programs (including Medi-Cal and CalFresh) to all beneficiaries within a geographic region who have been affected by a state of emergency or a health emergency. ***Potential CalOptima Health Impact*:** Extended Medi-Cal eligibility for certain members.	**01/23/2026** Died in Assembly Appropriations Committee **04/29/2025** Passed Assembly Health Committee **04/08/2025** Passed Assembly Human Services Committee	CalOptima Health: Watch
AB 2161 Bonta	**Community Engagement Implementation:** Would integrate federal community engagement requirements into the Medi-Cal program. Would prevent California from extending H.R. 1's work requirements to state-funded Medi-Cal populations. Would also minimize administrative load by automating verification using available data sources and require that any federal work requirement implementation be applied in the least burdensome way possible. ***Potential CalOptima Health Impact*:** Modifications to eligibility for certain members; minimized impact of new community engagement requirements.	**02/18/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch
AB 2201 Boerner	**Eligibility Redetermination Changes:** Would seek to align state provisions for Medi-Cal eligibility redeterminations with federal requirements, such as changing the current 12-month renewal cycle to a six-month cycle for adults covered under Medicaid Expansion. Additionally, would encourage counties to verify beneficiary income and assets through existing data sources to streamline the redetermination process. ***Potential CalOptima Health Impact*:** Modifications to eligibility redetermination for certain members.	**02/19/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2363 Bains	**Coverage Penalty Exemption:** Would prohibit the imposition of a penalty for not maintaining minimum essential health coverage on individuals enrolled in Medi-Cal in 2024 or 2025. ***Potential CalOptima Health Impact:*** Reduced financial penalties for certain current and future members.	**02/202026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch
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

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 660 Menjivar	**California Health and Human Services Data Exchange Framework (DxF):** Requires the Center for Data Insights and Innovation within California Health and Human Services Agency (CalHHS) to absorb all functions related to the DxF initiative, including the data sharing agreement and policies and procedures, by January 1, 2026. Additionally, expands DxF to include social services information. ***Potential CalOptima Health Impact:*** Increased care coordination with social service providers.	**10/03/2025** Signed into law	CalOptima Health: Watch
SB 987 Weber Pierson	**California Health Access Fund (CHAF):** Would require DHCS to administer the CHAF to ensure California residents who lose health care coverage due to the impacts of H.R. 1 (or other divestments from health care services) can continue to receive health care services and that providers are also reimbursed for these services. Furthermore, money in the fund would include deposits equal to the amount of any savings to the state that resulted from decreased enrollment in the Medi-Cal program caused by enrollment barriers from new federal policy changes. ***Potential CalOptima Health Impact:*** Extended health care benefits for certain future former members.	**02/05/2026** Introduced; referred to Senate Health Committee	CalOptima Health: Watch
AB 45 Bauer-Kahan	**Reproductive Data Privacy:** Prohibits the collection, use, disclosure, sale, sharing, or retention of the information of a person who is physically located at, or within a precise geolocation of, a family planning center, except any collection or use necessary to perform services or provide goods that have been requested. Also authorizes an aggrieved person to institute and prosecute a civil action against any person or organization in violation of these provisions. ***Potential CalOptima Health Impact:*** Increased safeguards regarding reproductive health information.	**09/26/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 257 Flora	**Specialty Telehealth Network Demonstration:** Would require the establishment of a demonstration project or grant program for a telehealth and other virtual services specialty care network designed to serve patients of safety-net providers. ***Potential CalOptima Health Impact:*** Expanded member access to telehealth specialists.	**01/23/2026** Died in Assembly Appropriations Committee **03/25/2025** Passed Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 316 Krell	**Artificial Intelligence Defenses:** Prohibits a defendant that developed or used artificial intelligence from asserting a defense that artificial intelligence autonomously caused the alleged harm to the plaintiff. ***Potential CalOptima Health Impact:*** Increased liability related to UM procedures.	**10/13/2025** Signed into law	CalOptima Health: Watch
AB 403 Ortega	**Medi-Cal Community Health Service Workers:** Would require DHCS to annually review the Community Health Worker (CHW) benefit and present an analysis to the Legislature beginning July 1, 2027. The analyses would include an assessment of Medi-Cal MCP outreach and education efforts, CHW utilization and services, demographic disaggregation of the CHWs and beneficiaries receiving services, and fee-for-service reimbursement data. ***Potential CalOptima Health Impact:*** New reporting requirements to DHCS.	**01/23/2026** Died in Assembly Appropriations Committee **03/25/2025** Passed Assembly Health Committee	CalOptima Health: Watch
AB 577 Wilson	**Prescription Drug Antisteering:** Would prohibit a health plan or pharmacy benefit manager (PBM) from engaging in specified steering practices, including requiring an enrollee to use a retail pharmacy for dispensing prescription oral medications and imposing any requirements, conditions or exclusions that discriminate against a physician in connection with dispensing prescription oral medications. Additionally, would require a health care provider, physician's office, clinic or infusion center to obtain consent from an enrollee and disclose a good faith estimate of the applicable cost-sharing amount before supplying or administering an injected or infused medication. ***Potential CalOptima Health Impact:*** Increased oversight of contracted PBM and referral processes.	**01/23/2026** Died in Assembly Appropriations Committee **04/29/2025** Passed Assembly Health Committee	CalOptima Health: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 688 Gonzalez	**Telehealth for All Act of 2025:** Beginning in 2028 and every two years thereafter, requires DHCS to use Medi-Cal data and other data sources to produce analyses in a publicly available Medi-Cal telehealth utilization report. ***Potential CalOptima Health Impact:*** New reporting requirements to DHCS.	**10/07/2025** Signed into law	CalOptima Health: Watch
AB 980 Arambula	**Health Plan Duty of Care:** As it pertains to the required "duty of ordinary care" by a health plan, would define "medically necessary health care service" to mean legally prescribed medical care that is reasonable and comports with the medical community standard. ***Potential CalOptima Health Impact:*** Modified UM procedures.	**01/16/2026** Died in Assembly Health Committee **04/22/2025** Re-referred to Assembly Health Committee	CalOptima Health: Watch
AB 2194 Valencia	**CalOptima Health Governance:** Would implement staggered terms on the CalOptima Health Board of Directors (Board), effective for the new terms expected to begin in August 2028. To accommodate a transition, the following three Board seats would serve initial two-year terms: 1. Current or former hospital administrator 2. Practicing licensed medical provider who is not affiliated with a health network 3. Accounting or public finance professional or actively licensed attorney In addition, would require CalOptima Health to provide any authorized representative of the Orange County Board of Supervisors with access to any books, documents or records that are reasonably necessary to review the conduct of its activities. ***Potential CalOptima Health Impact:*** Increased continuity of Board representation; increased disclosure of potentially privileged information to all five County Supervisors and an unknown number of County staff.	**02/19/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch County of Orange: Sponsor

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2565 Wallis	**Pharmacist Services Reporting:** Would require Medi-Cal MCPs to submit an annual report to DHCS containing information and data about pharmacist services that are within the jurisdiction of MCPs (and therefore not the FFS delivery system through the Medi-Cal Rx program). ***Potential CalOptima Health Impact:*** Increased reporting to DHCS.	**03/19/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch
Older Adult Services			
SB 242 Blakespear	**Medicare Supplemental Coverage Open Enrollment Periods:** Would make Medicare supplemental benefit plans available to qualified applicants with end stage renal disease under the age of 64 years. Would also create an annual open enrollment period for Medicare supplemental benefit plans and prohibit such plans from denying an application or adjusting premium pricing due to a preexisting condition. Additionally, would authorize premium rates offered to applicants during the open enrollment period to vary based on the applicant's age at the time of issue, but would prohibit premiums from varying based on age after the contract is issued. ***Potential CalOptima Health Impact:*** Expanded Medicare coverage options for dual-eligible members.	**01/23/2026** Died in Senate Appropriations Committee **04/30/2025** Passed Senate Health Committee	CalOptima Health: Watch CAHP: Oppose
SB 412 Limón	**Home Care Aides:** Requires a home care organization to ensure that a home care aide completes training related to the special care needs of clients with dementia prior to providing care and annually thereafter. ***Potential CalOptima Health Impact:*** New training requirements for PACE staff.	**10/06/2025** Signed into law	CalOptima Health: Watch
Providers			
SB 32 Weber Pierson	**Timely Access to Care:** Would require DHCS, DMHC and the California Department of Insurance to consult stakeholders for the development and adoption of geographic accessibility standards of perinatal units to ensure timely access for enrollees by July 1, 2027. ***Potential CalOptima Health Impact:*** Additional timely access standards; increased contracting with perinatal units.	**07/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **06/02/2025** Passed Senate floor	CalOptima Health: Watch LHPC: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 250 Ochoa Bogh	**Medi-Cal Provider Directory — SNFs:** Requires an annually updated provider directory issued by a Medi-Cal MCP to include SNFs as a searchable provider type. ***Potential CalOptima Health Impact:*** Modifications to CalOptima Health's online provider directory.	**10/03/2025** Signed into law	CalOptima Health: Watch
SB 306 Becker	**Prior Authorization Exemption:** No later than January 1, 2028, requires health plans — except Medi-Cal MCPs — to eliminate prior authorization for the most frequently approved health care services, except in cases of fraudulent provider activity or clinically inappropriate care. ***Potential CalOptima Health Impact:*** In future Covered California line of business, implementation of new UM procedures to assess prior authorization approval rates; decreased number of prior authorizations; decreased care coordination for members.	**10/06/2025** Signed into law	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
SB 504 Laird	**HIV Reporting:** Authorizes a health care provider for a patient with an HIV infection that has already been reported to a local health officer to communicate with a local health officer or CDPH to obtain public health recommendations on care and treatment or to refer the patient to services provided by CDPH. ***Potential CalOptima Health Impact:*** Increased coordination of care for HIV-positive members.	**10/13/2025** Signed into law	CalOptima Health: Watch
SB 1049 Pierson	**Claim Reimbursements:** Would grant a provider 90 days to submit a corrected claim after a health care plan denies a claim or sends a notice of overpayment for a claim based on a defect that could be rectified by submitting a corrected claim. Additionally, would prohibit denial of a corrected claim on the grounds that the provider did not submit the claim within the applicable filing deadline. ***Potential CalOptima Health Impact:*** Modified claims review process.	**02/13/2026** Introduced; referred to Senate Health Committee	CalOptima Health: Watch CAHP: Oppose Unless Amended

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 29 Arambula	**Adverse Childhood Experiences (ACEs) Screening Providers:** Would require DHCS to include community-based organizations, local health jurisdictions and doulas as qualified providers for ACEs trauma screenings and require clinical or other appropriate referrals as a condition of Medi-Cal payment for conducting such screenings. ***Potential CalOptima Health Impact:*** Increased access to care for pediatric members with ACEs.	**01/23/2026** Died in Assembly Appropriations Committee **04/01/2025** Passed Assembly Health Committee	CalOptima Health: Watch
AB 50 Bonta	**Over-the-Counter Contraceptives:** Allows pharmacists to provide over-the-counter hormonal contraceptives without following certain procedures and protocols, such as requiring patients to complete a self-screening tool. As such, these requirements are limited to prescription-only hormonal contraceptives. ***Potential CalOptima Health Impact:*** Increased member access to hormonal contraceptives.	**09/26/2025** Signed into law	CalOptima Health: Watch
AB 55 Bonta	**Alternative Birth Centers Licensing:** Removes the requirement for alternative birth centers to provide comprehensive perinatal services as a condition of CDPH licensing and Medi-Cal reimbursement. ***Potential CalOptima Health Impact:*** Decreased member access to comprehensive perinatal services; reduced operating requirements for alternative birth centers.	**10/11/2025** Signed into law	CalOptima Health: Watch LHPC: Support
AB 220 Jackson	**Medi-Cal Subacute Care Authorization:** Would require a provider seeking prior authorization for pediatric subacute or adult subacute care services under the Medi-Cal program to submit a specified form. Additionally, would prohibit a Medi-Cal MCP from developing or using its own criteria for medical necessity and from requiring a subsequent treatment authorization request upon a patient's return from a bed hold for acute hospitalization. ***Potential CalOptima Health Impact:*** Modified UM procedures and forms.	**09/04/2025** Passed Senate floor; referred to Assembly for concurrence in amendments **05/29/2025** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 280 Aguiar-Curry	**Provider Directory Accuracy:** Would require health plans — except Medi-Cal MCPs — to maintain accurate provider directories, starting with minimum 60% accuracy by July 1, 2026, and increasing to 95% by July 1, 2029, or otherwise receive administrative penalties. If a patient relies on inaccurate directory information, would require the provider to be reimbursed at the out-of-network rate without the patient incurring charges beyond in-network cost-sharing amounts. Would also allow DMHC to update standardized formats to collect directory information as well as establish methodologies to ensure accuracy, such as use of a central utility, by January 1, 2026. Additionally, would require a health plan to provide information about in-network providers to enrollees upon request, including whether the provider is accepting new patients at the time, and would limit the cost-sharing amounts an enrollee is required to pay for services from those providers under specified circumstances. Would also require that, within 30 days of receiving a request from a health plan, a provider must confirm that its information is current and accurate or update the required information. ***Potential CalOptima Health Impact:*** In future Covered California line of business, increased oversight of provider directory; increased coordination with contracted providers; increased penalty payments to DMHC.	**07/09/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/02/2025** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose
AB 375 Nguyen	**Qualified Autism Service Paraprofessional:** Would expand the definition of "health care provider" to also include a qualified autism service paraprofessional. ***Potential CalOptima Health Impact:*** Increased access to autism services for eligible members; additional provider contracting and credentialing.	**01/29/2026** Passed Assembly floor; referred to Senate	CalOptima Health: Watch
AB 416 Krell	**Involuntary Commitment:** Authorizes a person to be taken into custody by an emergency physician under the Lanterman-Petris-Short Act and exempts the emergency physician from criminal and civil liability. ***Potential CalOptima Health Impact:*** New legal standards for certain CalOptima Health providers.	**10/13/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 510 Addis	**Utilization Review Peer-to-Peer Review:** Would allow a provider to request review of a decision to delay, deny or modify health services by another physician or peer health care professional matching the specialty of the service within two business days. In urgent cases, responses must match the urgency of the patient's condition. If these deadlines are not met, the authorization request would be automatically approved. ***Potential CalOptima Health Impact***: Expedited and modified UM, grievance and appeals procedures for covered Medi-Cal benefits; increased hiring of specialists to review grievances and appeals.	**01/23/2026** Died in Assembly Appropriations Committee **04/22/2025** Passed Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
AB 512 Harabedian	**Prior Authorization Timelines:** Would have shortened the timeline for prior or concurrent authorization requests to no more than 24 hours via electronic submission or 48 hours via non-electronic submission for *urgent* requests and three business days via electronic submission or five business days via non-electronic submission for *standard* requests, starting from plan receipt of the information reasonably necessary and requested by the plan to make the determination. ***Potential CalOptima Health Impact***: Expedited and modified UM procedures for covered Medi-Cal benefits.	**10/06/2025** Vetoed	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
AB 517 Krell	**Wheelchair Prior Authorization:** Would prohibit a Medi-Cal MCP from requiring prior authorization for the repair of a Complex Rehabilitation Technology (CRT)-powered wheelchair, if the cost of repair does not exceed $1,250. Would also no longer require a prescription or documentation of medical necessity, if the wheelchair has already been approved for use by the patient. Additionally, would require supplier documentation of the repair. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**01/23/2026** Died in Assembly Appropriations Committee **04/08/2025** Passed Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 539 Schiavo	**One-Year Prior Authorization Approval:** Would require a prior authorization for a health care service to remain valid for a period of at least one year, or throughout the course of prescribed treatment if less than one year, from the date of approval. ***Potential CalOptima Health Impact:*** Modified UM procedures for covered Medi-Cal benefits; decreased number of prior authorizations; increased costs.	**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 of receipt of a completed application; otherwise, a credential is conditionally approved for 120 days, except as specified. A plan is required to notify the provider whether the application is complete within 10 days of receipt. Additionally, requires a health plan to subscribe to and use the Council for Affordable Quality Healthcare credentialing form on and after January 1, 2028. ***Potential CalOptima Health Impact:*** Expedited and modified credentialing procedures for future Covered California line of business.	**10/11/2025** Signed into law	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose Unless Amended
AB 1843 Elhawary	**Communicable Disease:** Would prohibit health plans from requiring authorization for direct-acting antiviral drugs needed for hepatitis C treatment. Additionally, would extend confidentiality protections to public health records for hepatitis B and C cases, unless necessary for care management. ***Potential CalOptima Health Impact:*** Modified UM procedures.	**02/11/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1887 Zbur	**Prescription Drug Coverage for Rare Diseases:** Would prohibit a health care service plan from imposing prior authorization, step therapy or other utilization review for a drug prescribed for a rare disease, unless a biosimilar, interchangeable biologic or generic version of the drug is available. ***Potential CalOptima Health Impact:*** Expanded covered benefit for members.	**02/13/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch
AB 2352 Valencia	**Nonprofit Public Benefit Corporations:** Would allow nonprofit public benefit corporations that offer nonspecialty mental health services to be enrolled as Medi-Cal providers. ***Potential CalOptima Health Impact:*** Increased number of contracted mental health providers; increased access to mental health services for Medi-Cal members.	**02/19/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch
AB 2457 Connolly	**Medi-Cal Provider Credentialing:** Would extend the requirements of AB 1041 (2025) to Medi-Cal MCPs. ***Potential CalOptima Health Impact:*** Expedited and modified credentialing procedures for Medi-Cal line of business.	**02/20/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch
Rates & Financing			
SB 339 Cabaldon	**Medi-Cal Laboratory Rates:** Would require Medi-Cal reimbursement rates for clinical laboratory or laboratory services to *equal* the lowest of the following metrics: 1. the amount billed; 2. the charge to the general public; 3. 100% of the lowest maximum allowance established by Medicare; or 4. a reimbursement rate based on an average of the lowest amount that other payers and state Medicaid programs are paying. For any such services related to the diagnosis and treatment of sexually transmitted infections on or after July 1, 2027, the Medi-Cal reimbursement rates shall not consider the rates described in clause (4) listed above. ***Potential CalOptima Health Impact*:** Increased payments to contracted clinical laboratories.	**04/29/2025** Passed Senate Judiciary Committee; referred to Senate Appropriations Committee **04/23/2025** Passed Senate Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1672 Solache	**PACE Rates:** Would modify how PACE rates are negotiated by eliminating the requirement for consultation during rate setting and instead mandating direct negotiation of rates. Additionally, would require DHCS to provide written responses to comments and the rationale for rate assumptions before federal submission. ***Potential CalOptima Health Impact:*** Modified rate-setting process for PACE line of business.	**02/17/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch CalPACE: Sponsor
AB 2036 Patel	**Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Reimbursement:** Would clarify how FQHC and RHC services are reimbursed on a per-visit basis, including how such Prospective Payment System (PPS) rates are set and adjusted based on necessary documentation. ***Potential CalOptima Health Impact:*** Improved access to care for members assigned to contracted FQHCs; improved financial stability of contracted FQHCs.	**02/17/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch
AB 2327 Lowenthal	**Subcontractor Rates:** Would require Medi-Cal MCPs operating as fully or partially delegated subcontractors to be compensated with actuarially sound rates starting January 1, 2027s. ***Potential CalOptima Health Impact:*** Modifications to rate setting for Medi-Cal subcontractors.	**02/19/2026** Introduced; referred to Assembly 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
CalPACE: California PACE Association
LHPC: Local Health Plans of California

Last Updated: March 23, 2026

2026 Federal Legislative Dates

January 5	119th Congress, 1st Session convenes
July 24–August 30	Summer recess for House
August 8–September 13	Summer recess for Senate
December 18	2nd session adjourns

Source: Floor Calendars, United States Congress: https://www.congress.gov/calendars-and-schedules

2026 State Legislative Dates

January 5	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
January 16	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2025
January 23	Last day for any committees to hear and report to the Floor any bills introduced in that house in 2025
January 31	Last day for each house to pass bills introduced in that house in 2025
February 20	Last day for legislation to be introduced in 2026
March 27–April 5	Spring recess
April 24	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2026
May 1	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house in 2026
May 15	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house in 2026
May 26–29	Floor session only
May 29	Last day for each house to pass bills introduced in that house in 2026
June 15	Budget bill must be passed by midnight
July 2	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 3–August 2	Summer recess
August 14	Last day for fiscal committees to report bills in their second house to the Floor
August 17–31	Floor session only
August 21	Last day to amend bills on the Floor
August 31	Last day for each house to pass bills; final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature

Source: Legislative Deadlines, California State Senate: https://www.senate.ca.gov/legislative-deadlines-calendar

About CalOptima Health

CalOptima Health is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to serve member health with excellence and dignity, respecting the value and needs of each person. We provide coverage through three major programs: Medi-Cal, OneCare (HMO D-SNP) and the Program of All-Inclusive Care for the Elderly (PACE)

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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

MAC/PAC Meeting

CMO Update

Richard Pitts, DO, PhD, Chief Medical 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.

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MEASLES 2026

Measles can be serious.

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

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

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

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

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

Long-term complications

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

CDC

www.cdc.gov/measles

You have the power to protect your child.

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

The Times of Israel + Follow 26.8K Followers

Year-old child dies of measles in Jerusalem, in 14th fatality of outbreak

NORTH AMERICA

Mexico reports 1st measles death of 2026 in Michoacán

ROBERT HERRIMAN
FEB 01, 2026

Protect yourself, and those around you who might have weakened immune systems by making sure you and others in your household are up to date with the MMR vaccine.

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CDC MEASLES DATA FROM 2025-2026

While majority of those hospitalized occurred in those < 5, they also occurred in adults

U.S. Cases

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

U.S. Hospitalizations

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

U.S. Deaths

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

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

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Measles Activity in California, 2026

As of February 2, 2026, nine confirmed measles cases have been reported.

Month of Rash Onset	Number of Cases	County of Cases
January 2026	9	Los Angeles, Napa, Orange, San Mateo, Shasta
February 2026	0	

These data are provisional and subject to change. CDPH will update this page every Tuesday.

Napa County

January 21, 2026
- Child returning from South Carolina

Orange County

January 28, 30, 31, 2026
- Young Adult who recently returned from international travel
- Toddler (no travel)
- LA case who traveled to Disneyland on January 28 (infectious period)

Los Angeles

January 30 and 31, 2026
- Resident who recently travelled internationally
- International traveler

February 2, 2026
- Resident who traveled internationally

Shasta County

January 31, 2026

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MEASLES OC CASES AND EXPOSURE

- Adult who recently traveled internationally
  - Sites case visited during infectious period:
    - Eos gym in Ladera Ranch
    - AFC UC in Ladera Ranch
    - Mission Hospital
  - 134 known exposures
- Toddler without travel
  - History of visitation to local public venue with many other international visitors
  - No known exposures during infectious period
- Los Angeles County Case-
  - International traveler who visited Disneyland while infectious 1/28/26
  - 65 known exposures

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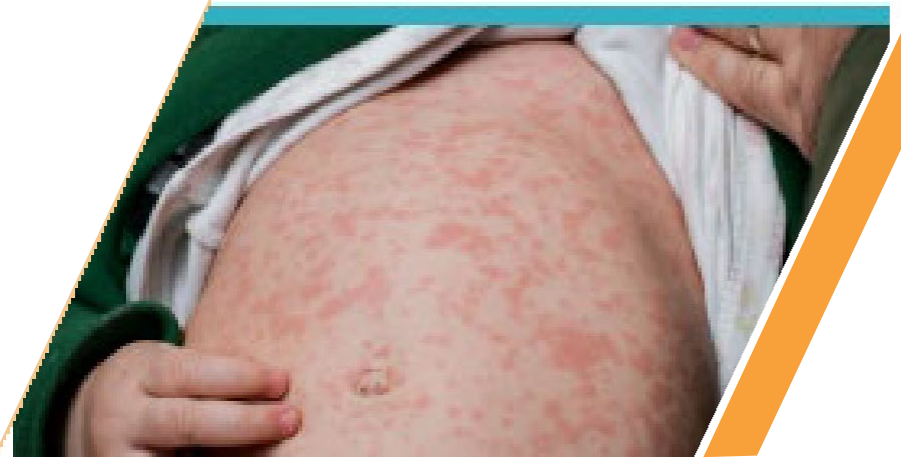
CDPH RECOMMENDATIONS- HEALTH ALERT CONTINUED



Suspect measles in patients with:

- Fever, rash and any of the “3 Cs" – cough, coryza, or conjunctivitis

- In the prior 3 weeks, any of:
  - attendance of an event or location with a known measles exposure,
  - international travel,
  - transit through airports, or
  - potential interactions with international visitors at theme parks or
  - other settings in the U.S.

CDPH RECOMMENDATIONS- HEALTH ALERT CONTINUED

Steps for providers to take when patients present with fever and rash:

- Mask the patient immediately, if possible.
- Bypass the waiting room: Keep the patient out of common areas.
- Isolate patient immediately, in an airborne infection isolation room (AIIR) if possible. See CDC and CDPH (PDF) infection control guidance. People with measles are contagious from 4 days before rash onset through 4 days after rash onset.
- All healthcare personnel entering the patient room, regardless of immune status, should use respiratory protection at least as effective as a FIT-tested N95 respirator, per Cal/OSHA requirements.
- Assess for risk factors and measles immunization status.
- Promptly telephone the local health de partment (LHD) to report **suspected** measles cases, even before laboratory confirmation, to discuss measles testing and control measures.
- Collect throat or NP swab and urine for polymerase chain reaction (PCR) testing. See Measles testing guidance. PCR is the preferred method for diagnosis and public health laboratories are the preferred setting for testing. Sending samples to commercial labs and not notifying public health of suspect cases can result in significant delays in diagnosis and infection prevention measures.

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IMMUNIZATION IS IMPORTANT

Ensure all patients are up to date on MMR vaccine.

CDPH recommendations for patients planning international travel:

- Infants 6 to 11 months old: 1 early dose of MMR vaccine, followed by 2 doses after the first birthday.
- Children 12 months and older: 2 doses of MMR vaccine. The second dose may be given as soon as 28 days after the first dose.
- Adults born during or after 1957 without evidence of immunity against measles: Documentation of 2 doses of MMR vaccine at least 28 days apart.

WHAT CAN VISITORS & RESIDENTS DO WHEN THERE ARE POTENTIAL EXPOSURES IN OC

- **Know your Immunity Status**
  - Especially if traveling to areas with identified measles case or outbreaks
  - People who have not received MMR vaccine previously
    or who have not had measles infection are **NOT** protected from measles
- **Stay informed** and **return any calls** received from **Public Health** or your **provider**
  - Press releases will note any areas of exposure and provide further guidance for those who may have been exposed
- **Notify your healthcare provider** if you are at **higher risk and** have been **exposed** to measles

  Especially:
  - Infants
  - Children and adults who are not vaccinated
  - People who are Pregnant
  - People with weakened immune systems
  - People who are partially immunized
- If you develop **symptoms** (fever, cough, runny nose, red eyes, or a rash)
  - **Stay home and avoid school, work or large gatherings** and
  - **Call a healthcare provider immediately**.
  - Do not go into a health care facility without calling first.

Image accessed from John Hopkins Bloomberg School of Public Health..
https://www.facebook.com/photo/?fbid=1042295304595662&set=pcb.1042299571261902

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HOW DO I PROTECT MYSELF

MMR vaccines are our best defense against the disease and its complications.

Vaccine Recommendations

Two doses of MMR (measles, mumps, rubella) vaccine for optimal protection

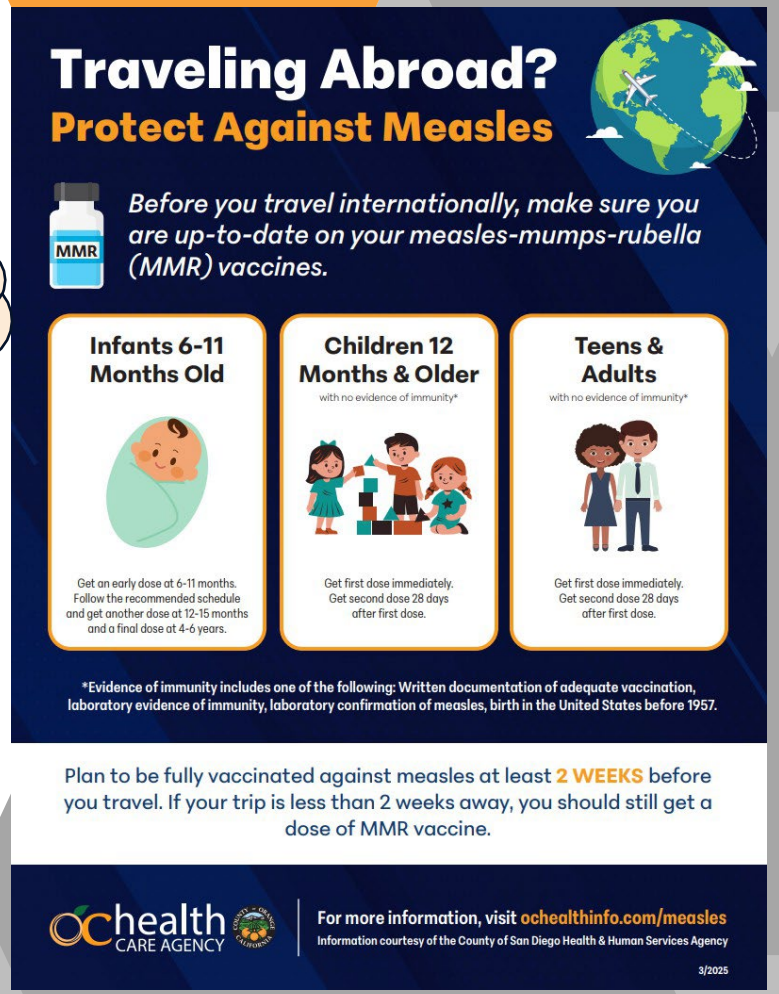
- **Children:** one dose at 12 months of age and another at 4–6 years
- **Older children, adolescents and adults** without documented doses of MMR vaccine:
  - Two doses of MMR separated by at least 28 days

Protection offered by MMR doses
1 dose: 93%
2 doses: 97%

- Talk to your health care provider or visit MyTurn.ca.gov to make a vaccine appointment.
- Unsure if you're vaccinated against measles?
  - Check your CA Digital Vaccine Record (DVR) or ask your healthcare provider.
  - If no records exist, get vaccinated.

What's Recommended ?

- Whether you're visiting family or exploring the world (or settings with potential of interaction with many travelers), ensure you are up to date with the MMR vaccine.
- It takes your body two to three weeks to get the most protection against measles after vaccination.
- Before international travel:
  - Babies 6–11 months of age should receive one dose of MMR vaccine.
  - Ensure everyone 12 months and older are up to date with two doses of MMR vaccine.
  - If they're not up to date, they should get two doses at least 28 days apart.



Protecting Against Measles
Arabic | Chinese Simplified | Chinese Traditional | English | Farsi | Korean | Russian | Spanish | Vietnamese

ADAPTED FROM CDPH
HTTPS://WWW.CDPH.CA.GOV/PROGRAMS/CID/DCDC/PAGES/IMMUNIZATION/MEASLES.ASPX

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WHAT TO DO IF YOU SUSPECT YOU HAVE A CASE OF MEASLES

- **Isolate suspect cases**
  - First put the person in respiratory isolation to limit additional exposures
  - If respiratory isolation room not available, can they wait outside or at least limit exposure to others as much as possible, close the door.
- **PPE:**
  - All healthcare workers entering the patient room regardless of immune status should use respiratory protection (N95)
- **Contact OC Public Health**
  - **Communicable Disease Control (CDCD) (714) 834-8180**
- **Collect specimens** (OP, NP or Urine)
  - Include Name, DOB, Contact information, language, measles immunity status if known

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WHAT TO DO IF YOU SUSPECT YOU HAVE A CASE OF MEASLES

Identify

- **Exposed Visitors/Clients/Patients and High- Risk Individuals**
  - Anyone in a shared airspace of the suspected case from an hour before until an hour after the person was put in isolation, consider waiting rooms, restrooms, hallways, offices where the person may have visited
  - **Are there exposed individuals who are high risk for severe disease (<12 months of age, severely immunocompromised, Non-immune pregnant women)?**
- **Exposed staff**
  - Including healthcare, administrative, security, facilities, environmental staff, or any EMS workers present
  - If you have Employee Health (EH), OC Public Health would expect EH to assess immunity of exposed staff

Create a line list (be ready to share with Public Health)

- Include
  - Name
  - DOB
  - Contact information, language
  - measles immunity status if known

WHAT HAPPENS IF THERE IS A CASE?

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

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WHAT WILL PUBLIC HEALTH DO WHEN YOU CALL THEM

- **What is the story**
  - Public Health will ask: How old, when did rash start, where on the body did the rash start, did they have a known exposure, travel
- **Specimen coordination**
  - Public Health can discuss how to collect specimens, we can arrange specimen transport, testing and results
- **Contacts**
  - Ask for line list of exposed
- **Provide recommendations on exposed individuals**
  - Who needs Post-exposure prophylaxis (PEP), what type of PEP
  - Who needs to quarantine
- **Monitoring**
  - Non-immune exposed individuals will be monitored, by phone, for the length of quarantine

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PROOF OF IMMUNITY AND POST EXPOSURE PROPHYLAXIS (PEP)

- **Proof of Immunity**
  - Two Doses of MMR Vaccine or positive measles IgG titer
- **PEP**
  - For those w/o a contraindication MMR vaccine given within 72 hours of exposure can prevent measles, including, in most circumstances the need to quarantine
  - For individuals at high risk for severe disease children < 12 months, individuals of any age who are severely immunocompromised, and non-immune pregnant people immunoglobulin (IG) either IMIG or IVIG can decrease the risk of severe disease if administered within six days of exposure.
  - Those who receive IG as PEP should quarantine and for a longer period as IG may delay the onset of disease
  - After 6 days IG PEP is not indicated as it is too late to interrupt illness

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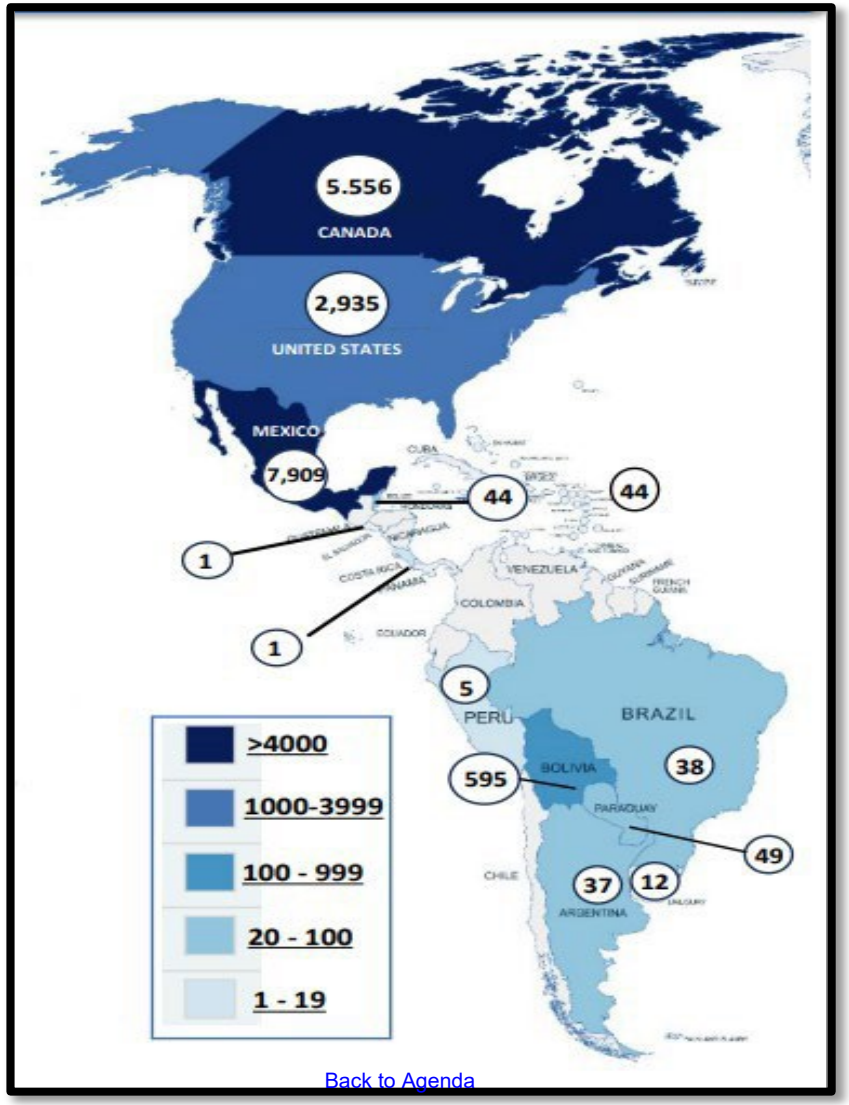
WHAT PROVIDERS & FACILITIES CAN DO

- **Document staff immune status NOW**
  - This will help avoid work exclusions
  - Give people time to find their documentation or to get titers drawn
- **Prepare for potential increased staffing needs to respond**
  - A single case linked to your facility can require significant effort and coordination with local officials for rapid notification and to ensure safety and health of staff and visitors.
- **Adjust clinical workflows and patient triage to minimize potential measles exposures**
  - Consider prescreening protocols
    - For patients with cough, conjunctivitis, fever or rash, recent travel to areas with outbreaks
    - Measles vaccination status
  - Consider:
    - Waiting outside
    - Isolation protocols

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

MEASLES REGIONALLY
THE AMERICAS, 2025-2026



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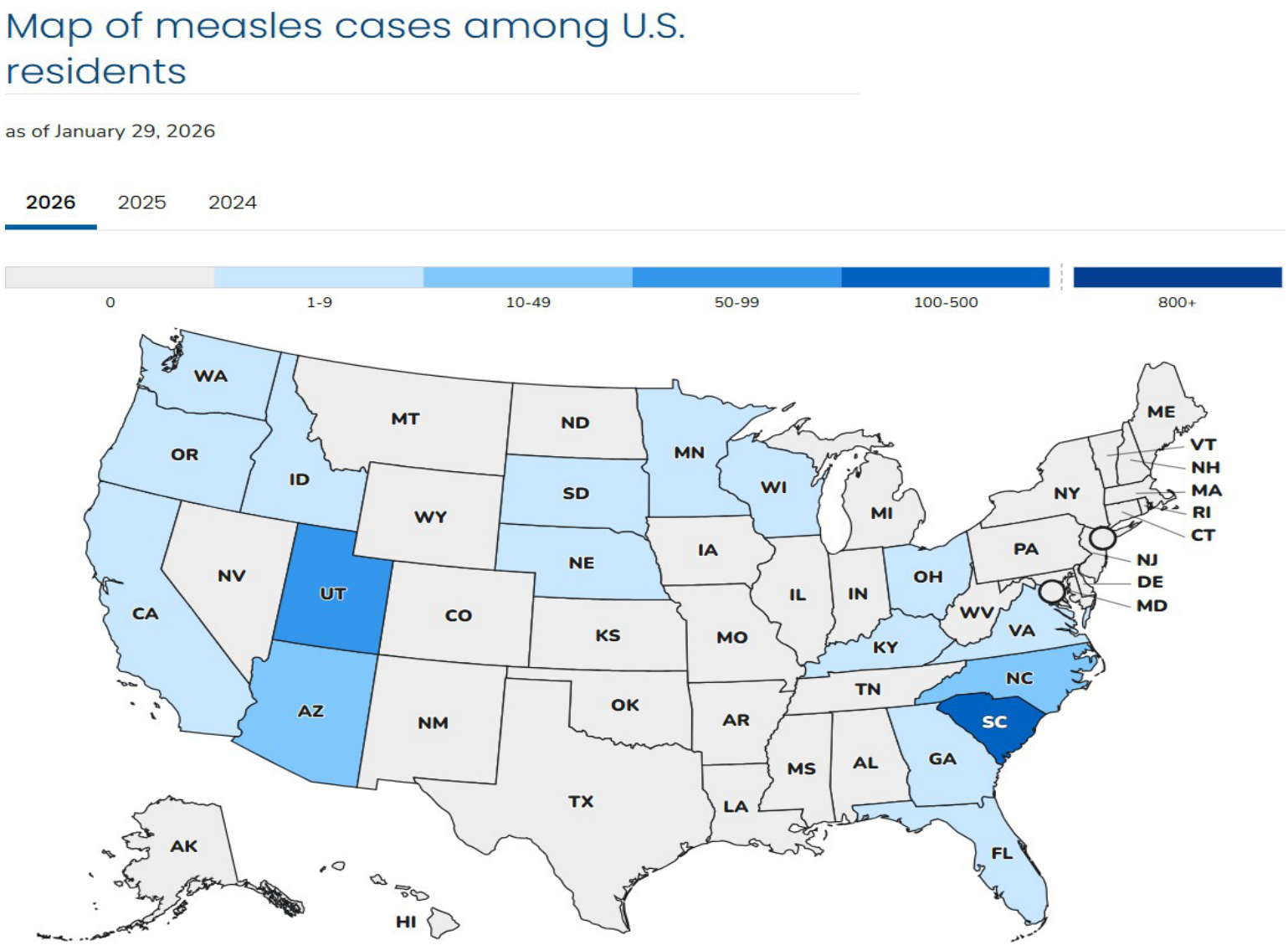
MEASLES IN THE US



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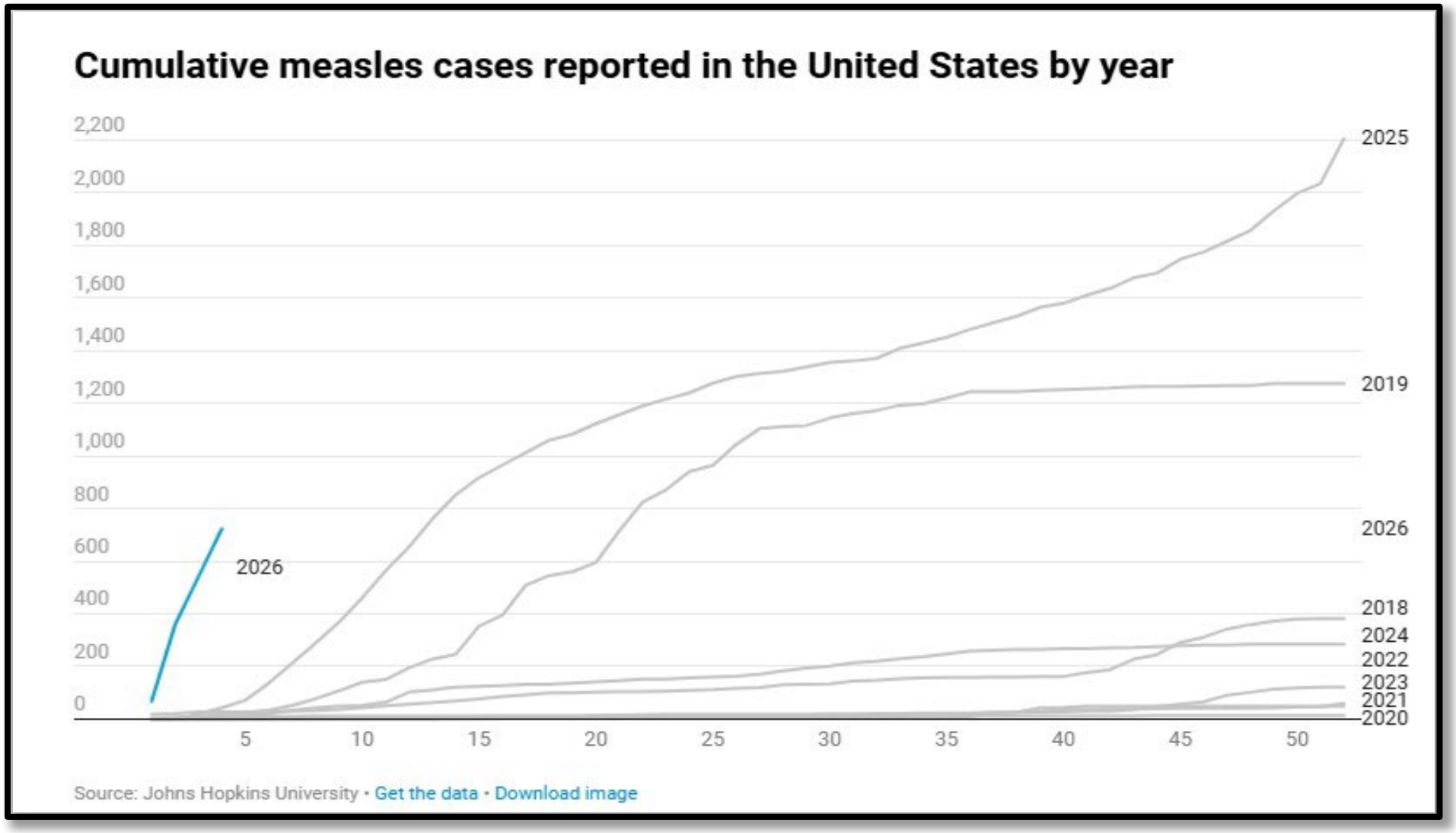
US MEASLES CASES



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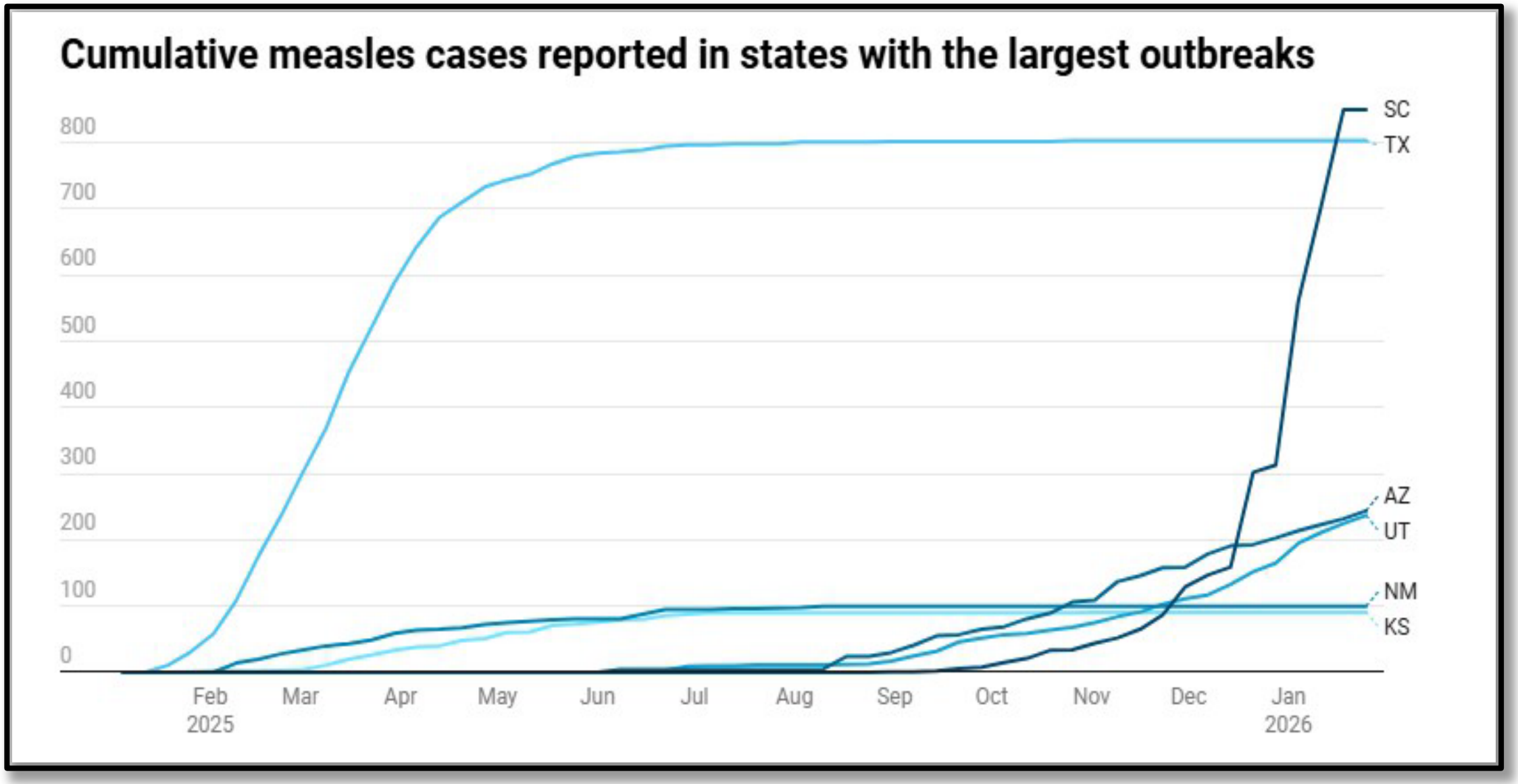

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CHANGE OF PACE

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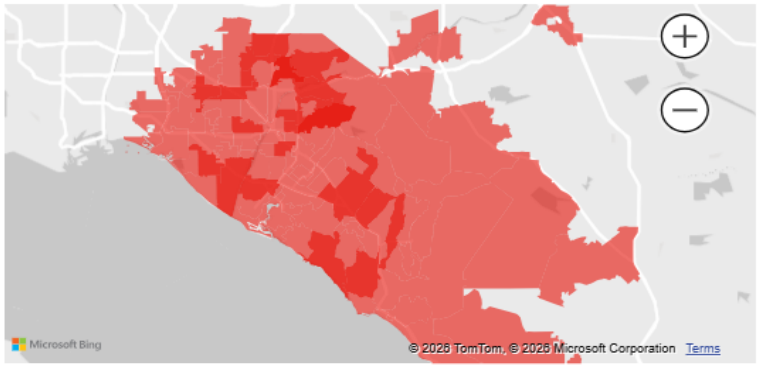
Orange County –EMS All Injury Dashboard

County of Orange
Health Care Agency
Emergency Medical Services
All Injury Dashboard
Data Source: OC-MEDS Prehospital Data

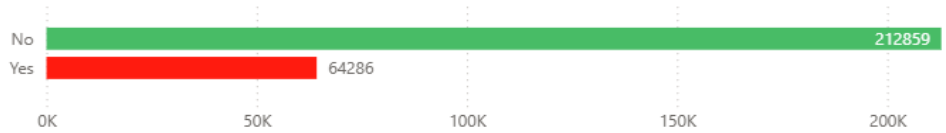
Date
1/1/2020 12/31/2025



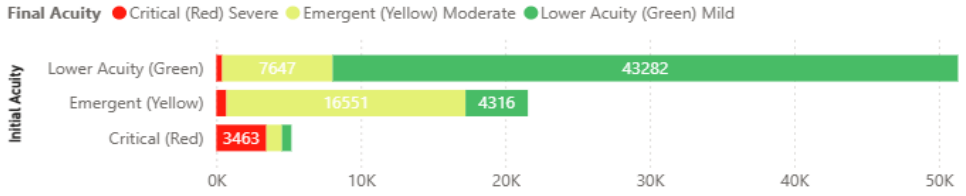
Top Causes of Injury

Cause Of Injury	#	%
Fall- Ground Level	125424	48.38%
Motor Vehicle Traffic Accident	53971	20.82%
Assault	16711	6.45%
Other	10560	4.07%
Fall- from a height	10537	4.06%
Auto vs. Pedestrian	6154	2.37%
Bicycle Accident - Traffic	4914	1.90%
Accidental Injury (hit, struck, other) by another person	4151	1.60%
Injury by object (not assault)	3557	1.37%
Bicycle Crash - Non-traffic (Bike vs Ped)	3384	1.31%
Stabbing/Cutting/Laceration (Not Assault)	3318	1.28%

Patient Met Field Trauma Triage Criteria?



Acuity of Patient Injury



Age

Age Range	#	%
85+	45981	16.59%
75-84	43284	15.62%
65-74	32209	11.62%
25-34	31504	11.37%
55-64	29826	10.76%
15-24	29283	10.57%
35-44	25036	9.03%
45-54	24047	8.68%

Sex

Sex	#	%
Male	138996	50.28%
Female	137450	49.72%

[OC- EMS All Injury Dashboard]

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CalOptima Health

Top Causes of Injury

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OC- EMS All Injury Dashboard

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CalOptima Health

MEMORANDUM

DATE: March 27, 2026

TO: CalOptima Health Board of Directors

FROM: Michael Hunn, Chief Executive Officer

SUBJECT: CEO Report — April 2, 2026, Board of Directors Meeting

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

A. Covered California Monthly Update

- **Plan Name Selected:** I'm pleased to share that a name has been selected for CalOptima Health's new Covered California plan, effective January 1, 2027. To help inform the naming process, CalOptima Health's marketing agency convened three focus groups — in English, Spanish and Vietnamese — with Orange County residents who are currently enrolled in a Covered California plan and/or are former CalOptima Health members. Participants told us they view CalOptima Health as a trusted, familiar brand strongly associated with affordability. We tested eight potential product names that leveraged the positive attributes of the CalOptima Health brand. Participants overwhelmingly preferred one name, which we selected: CalOptima Health Covered.
- **Operational Update:** With the recent filing of CalOptima Health's Letter of Intent to Apply to Covered California, staff members are preparing to submit CalOptima Health's application before the April 30 deadline. On March 23, CalOptima Health met with Covered California leadership again to better understand the upcoming submission and the impact of policy changes on enrollment. We are also continuing to work on the Department of Managed Health Care (DMHC) filing and recently responded to DMHC comments on our provider network filing. In addition, on March 19, Covered California presented its recommended 2027 benefit package, which is anticipated to be approved at the next Covered California Board of Directors meeting on April 16. The CalOptima Health board will vote on final approval at the August 6th, 2026, BOD meeting.

B. State Behavioral Health Infrastructure Program to Expand Resources in Orange County

In March, Governor Gavin Newsom announced $1.18 billion in Bond Behavioral Health Continuum Infrastructure Program (BHCIP) awards, including $17.3 million for Orange County. BHCIP will fund 66 projects across 130 behavioral health facilities. This announcement follows California's recent announcement of the first statewide drop in unsheltered homelessness in 15 years — a 9% decrease. Board Chair and Supervisor Vicente Sarmiento commented on the announcement in a press release: "Securing this funding is a major step forward for Orange County as we continue expanding access to mental-health and substance-use treatment. With $17.3 million supporting two critical projects, Orange County will add approximately 440 treatment beds, which significantly increases our ability to provide timely care for residents who need it most. By expanding capacity and improving coordination across

services, we are building a more responsive behavioral health system that promotes recovery and supports healthier, safer communities across Orange County. CalOptima Health is committed to supporting the behavioral health needs of our members through investments in programs such as WellSpaces in schools, counseling for school-aged children through Hazel Health, virtual behavioral health through TeleMed2U, dyadic services to build stronger family emotional connections and more.

C. Street Medicine Program Begins Serving Santa Ana

On March 9, CalOptima Health's newest Street Medicine Program launched operations in Santa Ana. Provider partner AltaMed Health Services is now working to establish relationships and trust among the estimated 871 unhoused individuals (per the 2024 Point in Time count) throughout the city. Currently, our Street Medicine Program serving the cities of Garden Grove, Costa Mesa and Anaheim has 428 enrolled members and has helped 50 members obtain permanent housing. On April 22, CalOptima Health will hold a press conference to formally announce our program alongside stakeholders and partners.

D. Skilled Nursing Facility Pilot Program Partners With the Southern California Hospitalist Network

CalOptima Health launched a pilot program with the Southern California Hospitalist Network (SCHN) on March 16 for new skilled nursing facility admissions. Under this initiative, SCHN will serve as the attending physician group for CalOptima Health Community Network (CHCN) Medi-Cal and OneCare members admitted for short-term skilled stays. This pilot marks a significant step forward in advancing our shared goals. By strengthening clinical oversight, bolstering care coordination and enhancing documentation standards, we are confident this model will support high-quality outcomes and improved regulatory readiness. This collaboration is a practical step toward tightening medical oversight, improving care coordination and elevating documentation standards — supporting quality outcomes and regulatory readiness.

E. DHCS Deploys H.R. 1 Texting Campaign to Affected Members

The California Department of Health Care Services (DHCS) has begun sending informational text messages to existing Medi-Cal Expansion members affected by the H.R. 1 changes. These members are part of what DHCS calls the Modified Adjusted Gross Income (MAGI) New Adult Group. The text messages note the new work and community engagement requirements, as well as the change from one-year to six-month renewals. Text messages will be sent 12 months and six months prior to a member's renewal date. The County of Orange Social Services Agency created a toolkit with social media content and graphics to raise awareness about the text message campaign. The toolkit is available in English, Spanish, Vietnamese, Korean, Chinese, Farsi and Arabic.

F. Providers and Members Invited to Participate on Advisory Committees

The CalOptima Health Board of Directors welcomes community input and recommendations on issues related to our programs. One way for providers, members or their authorized representatives, and community members to get involved is by participating in our various advisory committees. We encourage interested individuals with knowledge and support of California Children's Services (CCS), Medi-Cal or Medicare to apply for available committee seats by April 15, 2026. Service will begin following Board approval in August 2026. Service on these committees is voluntary, with members receiving no salary. However, Medi-Cal members, OneCare members and authorized family members serving on the Member Advisory Committee and Whole-Child Model Family Advisory Committee can receive a $100 stipend per meeting, plus mileage. For more information, please email Cheryl Simmons

at csimmons@caloptima.org, call 714-347-5785, or visit the Member Advisory Committee, Provider Advisory Committee or the Whole-Child Model Family Advisory Committee pages on our website.

G. Orange County Workforce Development Collaborative Is Formed

CalOptima Health is launching an Orange County Workforce Development Collaborative, in partnership with the Orange County Department of Education (OCDE) and the Orange County Business Council. The collaborative will bring together education institutions, provider organizations and community workforce development organizations to design and develop programs and initiatives to increase and sustain the health care workforce serving Medi-Cal members. Community partners are encouraged to join to collaborate with peers, share best practices and contribute to impactful solutions that address health care workforce shortages and challenges in Orange County. OCDE will facilitate in-person stakeholder meetings on Tuesday, April 21, and Wednesday, May 20. To learn more, reach out to StrategicDevelopment@caloptima.org.

H. CalOptima Health Announces New Unsolicited Grant Request Process

Our grants department has important updates regarding how we handle unsolicited grant requests. To streamline our response and ensure consistency in our approach, we have established a portal where these requesters can submit all relevant information (scroll down on our website here to the unsolicited portal link). These new procedures will help us intake and process requests consistently, ensuring that every proposal receives fair consideration. CalOptima Health provides most grant funding through formal, competitive notice of funding opportunities. The link above accepts unsolicited grant requests, although approval through this channel is infrequent and highly limited. Throughout this process, subject matter experts and departmental business owners will be engaged to review such requests. Additionally, the community investment committee will conduct a final review to ensure alignment with our goals and standards.

I. CalOptima Health Member Video Series Honored with National Advertising Awards

The ADDY Award is the advertising industry's largest (more than 25,000 entries each year) and most representative competition, recognizing creative excellence across all media. Conducted annually by the American Advertising Federation, it honors the best creative work in local, district and national competitions. The CalOptima Health Member Stories series was recently recognized with a Silver ADDY, and the member story video about Matt Hurst received a Bronze ADDY at the 2026 awards. Find the complete Member Stories series here.

J. CalOptima Health Receives Robust News Coverage

- On March 2, NBC4 Los Angeles interviewed Chief Operating Officer Yunkyung Kim for a segment on why low-income health care enrollment is declining in Orange County.
- On March 5, CalMatters published an article, "Trump's Medicaid work mandate could kick thousands of homeless Californians off coverage," and interviewed Kelly Bruno-Nelson, DSW, Executive Director, Medi-Cal/CalAIM.
- On March 22, the Orange County Register interviewed Chief Executive Officer Michael Hunn about the impact of H.R. 1 and hospital cuts.

CalOptima Health

Fast Facts
April 2026

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

Membership Data* (as of February 28, 2026)

Total CalOptima Health Membership

850,253

Prior month: 857,663

Program	Members
Medi-Cal	831,114
OneCare (HMO D-SNP)	18,593
Program of All-Inclusive Care for the Elderly (PACE)	546

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

Key Financial Indicators (for the month ended February 28, 2026)

	Dashboard	YTD Actual	Actual vs. Budget ($)	Actual vs. Budget (%)
Operating Income/(Loss)	●	$127.4M	$97.1M	320.5%
Non-Operating Income/(Loss)	●	$75.9M	$10.4M	15.8%
Covered California Start-up Expenses	●	($3.1M)	$3.9M	55.7%
Bottom Line (Change in Net Assets)	●	$200.2M	$111.4M	125.4%
Medical Loss Ratio (MLR) *(Percent of every dollar spent on member care)*	●	91.1%	---	(1.7%)
Administrative Loss Ratio (ALR) *(Percent of every dollar spent on overhead costs)*	●	5.1%	---	1.3%

Notes:
- For additional financial details, refer to the financial packages included in the Board of Directors meeting materials.
- Adjusted MLR (without the estimated provider rate increases funded by reserves) is 86.9%.

Reserve Summary (as of February 28, 2026)

	Amount (in millions)
Board Designated Reserves*	$1,637.1
Statutory Designated Reserves	$137.1
Capital Assets (Net of depreciation)	$111.6
Unspent Balance of Allocated Resources	$346.2
Unspent Balance of Board Approved Provider Rate Increase**	$175.4
Unallocated Resources*	$593.4
Total Net Assets	$3,000.8

* Total of Designated Reserves and Unallocated Resources can support approximately 204 days of CalOptima Health's current operations.

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

Total Annual Budgeted Revenue **$4.7 Billion**

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

CalOptima Health Fast Facts

April 2026

Personnel Summary (as of March 7, 2026, pay period)

	Filled	Open	Vacancy % Administrative	Vacancy % Medical	Vacancy % Combined
Staff	1,364.75	70.5	53.78%	46.22%	4.91%
Supervisor	81	6	33.33%	66.67%	6.9%
Manager	115	9	77.78%	22.22%	7.26%
Director	81	7.5	66.67%	33.33%	8.47%
Executive	21	1	100%	---%	4.55%
Total FTE Count	1,662.75	94	66.31%	33.69%	5.35%

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

Provider Network Data (as of March 18, 2026)

	Number of Providers
Primary Care Providers	1,314
Specialists	8,204
Pharmacies	494
Acute and Rehab Hospitals	42
Community Health Centers	73
Long-Term Care Facilities	244

Treatment Authorizations (as of January 31, 2026)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	33.96 hours
Prior Authorization – Urgent	72 hours	4.18 hours
Prior Authorization – Routine	5 days	0.34 days

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

Member Demographics (as of February 28, 2026)

Member Age

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

Language Preference

English	57%
Spanish	29%
Vietnamese	9%
Korean	2%
Farsi	1%
Other	1%
Chinese	<1%
Arabic	<1%
Russian	<1%

Medi-Cal Aid Category

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