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

SEPTEMBER 4, 2025
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

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

CHIEF EXECUTIVE OFFICER
Michael Hunn

OUTSIDE GENERAL COUNSEL
James Novello
Kennaday Leavitt

CLERK OF THE BOARD
Sharon Dwiers

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

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

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

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at: **https://us02web.zoom.us/webinar/register/WN__uf9rkZOTpORsh8MxU9ibw** to Join the Meeting.
Webinar ID: **886 4539 4088**
Passcode: **287788** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS
1. Chief Executive Officer Report

ADVISORY COMMITTEE UPDATES
2. Member Advisory Committee and Provider Advisory Committee Update

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

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

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

5. Approve Actions Related to Covered California Administrative Services Agreements

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

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

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

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

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

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

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

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

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

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

REPORTS/DISCUSSION ITEMS

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

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

18. Approve Modifications to CalOptima Health Purchasing Policy

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

CLOSED SESSION

CS-1. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Government Code section 54956.9(d)(4): 1 case

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

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

To **Register** in advance for this webinar:
https://us02web.zoom.us/webinar/register/WN__uf9rkZOTpORsh8MxU9ibw

To **Join** this webinar:
https://us02web.zoom.us/s/88645394088?pwd=Ck6DMbxHwUKXnybgb44TcV6ccy7QlK.1

Phone one-tap:
+16694449171,,88645394088#,,,,*287788# US
+16699009128,,88645394088#,,,,*287788# US (San Jose)

Join via audio:
+1 669 444 9171 US
+1 669 900 9128 US (San Jose)
+1 253 205 0468 US
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
+1 719 359 4580 US
+1 309 205 3325 US
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Webinar ID: 886 4539 4088
Passcode: 287788

International numbers available: **https://us02web.zoom.us/u/kbyeDjb6MW**

MEMORANDUM

DATE: August 29, 2025

TO: CalOptima Health Board of Directors

FROM: Michael Hunn, Chief Executive Officer

SUBJECT: CEO Report — September 4, 2025, Board of Directors Meeting

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

A. Covered California Monthly Update

CalOptima Health continues to prepare for the launch of a Covered California line of business, effective January 1, 2027. Since submitting the initial filing to expand the scope of CalOptima Health's current Knox-Keene Act license, the California Department of Managed Health Care (DMHC) has provided comments, and we have responded with revised exhibits. In addition, with the recent completion of the operational gap analysis by Deloitte Consulting LLP, staff have initiated several new workstreams to discuss and implement solutions in order to achieve operational readiness over the next year. Lastly, CalOptima Health continues to negotiate provider contracts and execute amendments with several existing vendors to include Covered California in their scopes of service.

B. CalOptima Health Prepares Fiscal Year (FY) 2025–26 Enacted State Budget Highlights

Following the recent enactment of a final FY 2025–26 state budget package, Government Affairs staff prepared a one-page document to highlight key Medi-Cal provisions that will likely be of significant impact to CalOptima Health. Of note, the final state budget did not account for any potential impacts from the federal budget reconciliation legislation (H.R. 1) that was also recently enacted and highlighted in August's CEO Report. At this time, it is still unknown whether the state budget will be amended in a special session this fall or if the State Legislature will wait until next year's standard budget process to incorporate federal impacts. Find the document at the end of my CEO Report.

C. Federal Updates

- **CMS Launches Nationwide Push to Remove Ineligible Medicaid Enrollees**
  On August 19, the U.S. Centers for Medicare & Medicaid Services (CMS) launched an oversight initiative to ensure that enrollees in Medicaid are U.S. citizens, U.S. nationals or have a satisfactory immigration status. CMS will begin providing states with monthly enrollment reports identifying individuals whose citizenship or immigration status could not be confirmed through federal databases. States will be responsible for reviewing cases, verifying the citizenship or immigration status of identified individuals, requesting additional documentation if needed, and taking appropriate actions when necessary, including adjusting coverage or enforcing non-citizen eligibility rules. CMS sent the first set of reports to states on the day of the announcement, along with guidance that it expects states to take quick action and will

monitor progress monthly. More information will be shared as it is made available, including any response from the California Department of Health Care Services (DHCS).

- **HHS Reinterprets Federal Public Benefit**
  The U.S. Department of Health and Human Services (HHS) recently published a significant policy notice that redefines "federal public benefit" as originally interpreted through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). In doing so, HHS is disallowing several more programs from being available to individuals without satisfactory immigration status, including the Health Center Program, Head Start, Community Services Block Grant and many others. Of note, Medicaid, Medicare and the Supplemental Nutrition Assistance Program (SNAP) have always been included on the disallowed program list. While the policy notice was effective immediately, California Attorney General Rob Bonta has since joined 20 other state attorneys general in filing a lawsuit to temporarily halt implementation of the notice through at least September 3.

- **White House Issues Executive Order on Homelessness**
  Recently, the White House released an executive order (EO) that directs federal agencies to address homelessness on multiple fronts, with particular attention to mental health and substance use disorder issues. Among its directives, the EO will make additional federal funds available for mental health beds, expand funding to federally qualified health centers and certified community behavioral health clinics for crisis intervention services, and make emergency funds available for encampment removals.

D. Transitional Rent Benefit Provides a Bridge to Permanent Housing

CalOptima Health will implement CalAIM's 15th Community Support — Transitional Rent — on January 1, 2026. Per DHCS, Community Supports are services provided by Medi-Cal managed care plans (MCP) to address members' health-related social needs, help them live healthier lives and avoid costlier levels of care. Members may receive a Community Supports service if they meet the eligibility criteria and if the MCP determines it is a medically appropriate and cost-effective alternative to services covered under the California Medicaid State Plan. Transitional Rent provides up to six months of rent for members who are experiencing or at risk of homelessness and meet certain additional eligibility criteria. Transitional Rent is a time-limited opportunity to help a member exit homelessness or remove the risk of entering homelessness and establish a bridge to permanent housing. The initial mandatory population of focus will be those who have significant behavioral health needs. Therefore, DHCS recommends that MCPs partner with their county behavioral health agency to operationalize this new service. CalOptima Health is fortunate to have an existing partnership/contract with our county behavioral health agency for Enhanced Care Management and Community Supports and plans to contract with the agency as the sole Transitional Rent provider.

E. Press Release Announces Selection of Santa Ana Street Medicine Provider

On August 13, CalOptima Health distributed a press release announcing AltaMed Health Services as the Board-approved Street Medicine Program provider in Santa Ana. Selected through a competitive process, AltaMed will receive a two-year, up to $4.3 million grant to implement CalOptima Health's specific Street Medicine Program model. "AltaMed is proud to expand our community outreach through this new program," said Cástulo de la Rocha, AltaMed President and CEO. "We share CalOptima Health's mission in providing access to care and treating all members with dignity and respect. AltaMed has been providing health services in Santa Ana for the past 17 years and is equipped

to serve the most vulnerable residents in this community and ensure they can experience the benefits of this impactful program."

F. Russian Added as New Threshold Language

On February 22, 2025, DHCS distributed revised APL 25-005 to provide translated written member information to potential members, using a qualified translator for threshold languages determined by DHCS. The APL reflects Russian as an eighth threshold language for Orange County. As required, CalOptima Health began providing Russian-translated written member information and translation services to members on August 11, 2025.

G. CalOptima Health and Orange County Medical Association Host Town Hall

CalOptima Health and the Orange County Medical Association hosted a virtual town hall for providers on August 14 to discuss the impacts of H.R. 1 on the physician community. California Medical Association Vice President Elizabeth McNeil provided details on the provisions of the bill that impact Medi-Cal, and I shared CalOptima Health's efforts to communicate with members and providers, collaborate with stakeholders, and shape the implementation to minimize disruption in our community.

H. CalOptima Health Gains Media Coverage

- On August 13, the Orange County Register featured a KFF Health News story on the front page, "Fear Pandemic: Immigration Raids Push Patients Back Into Telehealth." The original article was published online on August 6. I was interviewed along with Dr. Jacob Sweidan, a member of our Provider Advisory Committee.
- In the August 18 issue of the Orange County Business Journal, Kelly Bruno-Nelson, DSW, Executive Director of Medi-Cal/CalAIM and I were pictured presenting a $1 million grant to Sloane Keane, CEO, Big Brothers Big Sisters of Orange County. The grant will expand the organization's mentorship program as a long-term, preventive measure to reduce the risk of homelessness among vulnerable youth in Orange County.

CalOptima Health

Fast Facts
September 2025

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

Membership Data* (as of July 31, 2025)

Total CalOptima Health Membership

904,278

Program	Members
Medi-Cal	885,779
OneCare (HMO D-SNP)	17,971
Program of All-Inclusive Care for the Elderly (PACE)	528

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

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

	Dashboard	YTD Actual	Actual vs. Budget ($)	Actual vs. Budget (%)
Operating Income/(Loss)		$9.3M	$5.7M	160.3%
Non-Operating Income/(Loss)		$5.2M	($3.0M)	(36.2%)
Covered California Start-up Expenses		($0.1M)	($0.6M)	84.7%
Bottom Line (Change in Net Assets)		$14.4M	$3.3M	30.2%
Medical Loss Ratio (MLR) *(Percent of every dollar spent on member care)*		92.5%	---	(0.4%)
Administrative Loss Ratio (ALR) *(Percent of every dollar spent on overhead costs)*		5.2%	---	1.2%

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 88.1%.

Reserve Summary (as of July 31, 2025)

	Amount (in millions)
Board Designated Reserves*	$1,584.6
Statutory Designated Reserves	$132.3
Capital Assets (Net of depreciation)	$102.7
Unspent Balance of Allocated Resources	$402.0
Unspent Balance of Board Approved Provider Rate Increase**	$298.2
Unallocated Resources*	$295.2
Total Net Assets	$2,815.0

* Total of Board-designated reserves and unallocated resources can support approximately 169 days of CalOptima Health's current operations.

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

Total Annual Budgeted Revenue **$4.7 Billion**

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

CalOptima Health Fast Facts

September 2025

Personnel Summary (as of August 9, 2025, pay period)

	Filled	Open	Vacancy % Medical	Vacancy % Administrative	Vacancy % Combined
Staff	1,352	83.25	39.7%	60.3%	5.8%
Supervisor	84	3	0%	100%	3.45%
Manager	112	14	14.29%	85.71%	11.11%
Director	72	14.5	24.14%	75.86%	16.76%
Executive	21	0	---%	---%	---%
Total FTE Count	1,641	115.8	47.89%	52.11%	6.59%

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

Provider Network Data (as of August 25, 2025)

	Number of Providers
Primary Care Providers	1,300
Specialists	7,668
Pharmacies	498
Acute and Rehab Hospitals	43
Community Health Centers	68
Long-Term Care Facilities	224

Treatment Authorizations (as of June 30, 2025)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	34 hours
Prior Authorization – Urgent	72 hours	16.57 hours
Prior Authorization – Routine	5 days	1.96 days

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

Member Demographics (as of July 31, 2025)

Member Age	
0 to 5	7%
6 to 18	22%
19 to 44	35%
45 to 64	20%
65 +	16%

Language Preference	
English	54%
Spanish	31%
Vietnamese	9%
Other	2%
Korean	2%
Farsi	1%
Chinese	<1%
Arabic	<1%

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

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.

Board of Directors Meeting
September 4, 2025

Regular Joint Meeting of the Member Advisory Committee and the Provider Advisory Committee

Report to the Board

The Member Advisory Committee (MAC), and the Provider Advisory Committee (PAC) held a regular joint meeting on August 14, 2025.

The MAC approved a recommendation for changes to MAC seat composition as requested by Department of Health Care Services (DHCS). Staff will submit a COBAR for the October 2, 2025 Board meeting requesting approval on these changes. MAC also approved a recommendation to change the stipend for Medi-Cal Members and OneCare Members or their authorized family members who hold a member seat on the MAC to increase the stipend from $50 to $100 and they will have a choice of receiving the stipend as a check or as a gift card. The current stipend is paid by check only.

The PAC approved a recommendation to appoint Jonathan Megerian, MD, Ph.D. FAAP to fill the open Physician seat on the committee.

Heather Sedillo, Director, Grievance and Appeals, presented an overview of the 2025 Quarter 2 (Q2) Member Trend Report. She reviewed the definitions, executive summary, grievance volume and trends, grievance actions taken, appeals volume and trends, and appeals actions taken. She reported that CalOptima Health received a total of 5,056 grievances and appeals across both lines of business during Q2. The average turnaround time for resolving both grievances and appeals was 23 days and she noted that Medi-Cal experienced a notable increase in grievances, rising from 3,675 in Q1 to 4,506 in Q2 equating to a 23% increase. OneCare also saw a significant rise, with grievances increasing from 371 in Q1 to 550 in Q2, representing a 48% increase. Ms. Sedillo emphasized that such increases from Q1 to Q2 are typical and consistent with historical year-over-year patterns.

Michaell Silva-Rose, DrPH, LCSW, Chief Health Equity Officer, began her presentation by clarifying the distinction between several assessments CalOptima Health has shared over the past year. She referenced the Population Needs Assessment (PNA), an annual National Committee for Quality Assurance (NCQA) requirement completed in April 2025, which was distributed to stakeholders in May. Members who did not receive the report were encouraged to contact Cheryl Simmons. Dr. Rose also mentioned CalOptima Health's involvement in the Orange County Health Care Agency's (OCHCA) Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP), with a joint CHA planned for 2028.

Dr. Rose also presented the Member Population Health Needs Assessment (MPHNA), which launched earlier this year following a Board recommendation. This comprehensive assessment aims to inform health equity strategies, community investments, and program development for CalOptima Health members. Dr. Rose noted that CalOptima Health is partnering with the National Opinion Research Center (NORC) to implement a three-pronged approach: member and provider surveys, key informant interviews, and community focus groups. Additionally, the MPHNA will assess community assets and barriers to care, using a strength-based approach to develop targeted interventions and asset maps. This work supports National Committee for Quality Assurance (NCQA) accreditation and lays the groundwork for the 2028 CHA. The final MPHNA report is expected by Q2 2026.

Dr. Rose also thanked the MAC and PAC committees for their input in co-designing the member and provider surveys. Feedback provided by the committees helped refine the instruments and focus areas. She also highlighted a collaborative session with the OCHCA, where 18 community-based organizations contributed valuable input on both the assessment and asset mapping. Dr. Rose emphasized that the member survey will assess needs, barriers to care, service gaps, and health status and that it would be translated into threshold languages and take approximately 12–15 minutes to complete. Distribution would use both random and convenience sampling, and participants would receive a gift card. The survey is expected to launch in late September 2025 as it is pending the Department of Health Care Services (DHCS) approval.

Dr. Rose also discussed the provider survey, which launched at the end of July and evaluated provider perspectives on member needs and access barriers. Providers received an email from NORC, and those who did not are encouraged to contact Cheryl Simmons for a link to the survey. Dr. Rose noted that the survey would be open through August 29, 2025 and outreach efforts were ongoing to maximize participation. As of the most recent update, 127 surveys had been completed, with 40 in progress. All providers are encouraged to participate, regardless of their network affiliations.

Dr. Rose reviewed upcoming focus groups and in-depth interviews, which will be conducted in partnership with the Community Action Partnership. These qualitative methods will complement the survey data and further inform the MPHNA.

Carlos Soto, Manager of Cultural and Linguistic Services, presented on current Cultural and Linguistic services and noted that CalOptima Health offers interpreter and translation services to all members. Currently, the team is focused on translating materials for this year's Annual Notice of Change (ANOC), ensuring all threshold languages are covered. They are working diligently to meet translation timelines so that materials can be mailed by the September 30 deadline.

Mr. Soto also reviewed ongoing services and utilization trends and noted that the Cultural and Linguistics' team continues to process written translation requests, as well as telephonic, video relay (VRI), and face-to-face interpreter services. Utilization data is regularly analyzed to identify trends and make necessary adjustments, ensuring timely and adequate language services. Spanish and Vietnamese remain the most requested languages due to the size of those populations served. Recently, there has been a noticeable increase in Russian language requests, likely due to a growing Russian population in Orange County. As a result, Russian has been added as a new threshold language, which became effective in August. He also noted that the Cultural and Linguistics' department also evaluated satisfaction with language services through staff and member surveys. A staff survey, distributed via

internal communications, received 73 responses, all of which were very positive. A member survey was mailed to 32,480 individuals, yielding a 6% response rate, with similarly positive feedback.

Mr. Soto also discussed how CalOptima Health had conducted a Sexual Orientation and Gender Identity (SOGI) survey targeting members aged 18 and older. A total of 61,109 surveys were mailed, resulting in a 9% response rate. The collected data is stored in the core eligibility system and updated as needed. Member demographic information, including SOGI data, continues to be shared with practitioners to support inclusive care.

Yunkyung Kim, Chief Operating Officer, provided an update on current membership trends and noted that while membership remains relatively flat, there is an expectation of potential declines in the coming months due to the ongoing wave of redeterminations. Early data from August suggests more fluctuation than in previous months and noted that membership data typically takes about two months to stabilize, as some individuals are re-enrolled after initial disenrollment.

Ms. Kim also discussed changes to the Grant Management Policy at the August Board meeting and noted that the changes were relevant for both current and future grantees. One key clarification was around grant eligibility and noted that going forward, only nonprofit organizations, government entities, municipalities, educational institutions, and tribal entities will be eligible to receive grants. For-profit organizations were excluded from eligibility, although CalOptima Health continues to engage with them through other contractual means. The Board also discussed the future of grant funding and noted that while CalOptima Health had been able to make significant grant investments in recent years, this level of funding is expected to decrease due to budget constraints and anticipates fewer grant opportunities in the coming years compared to the recent past.

Ms. Kim also discussed CalOptima Health's commitment to inclusive grantmaking by ensuring that small and qualified organizations have fair access to funding opportunities and that initially there was consideration of limiting organizations to one grant at a time, but after receiving significant feedback, that idea was discarded. Organizations may now hold multiple grants, provided they are not duplicative in nature. She noted that updates were made to grant monitoring practices—such as requiring grantees to spend current funds before requesting additional ones. These practices were already in place informally but are now formally included in policy. The updated grant policy is now effective and will be shared with current and future grantees. She also reviewed the Retroactive Authorization Policy Adjustment and noted that earlier this year, CalOptima Health had extended the retroactive authorization window to one year. However, this change proved impractical due to conflicts with claims submission timelines. As a result, the policy is now reverting to a 60-day retroactive authorization window, aligning with Medicare standards.

Ms. Kim concluded her report with updates on provider transitions within CalOptima Health's Direct Network noting that previously, when a provider left a health network, members remained with the network. An exception was made for the Community Care Network (CCN), allowing providers to recommend member reassignment if they joined another contracted network. However, this created unintended issues for high-risk members, such as those with End-Stage Renal Disease (ESRD) who are assigned to the Direct Network and cannot choose their network. In order to preserve continuity of care, the policy is being modified to allow providers leaving CCN to continue caring for these members within the direct network. This correction is expected to be implemented in September. She also provided a brief update on how CalOptima Health has been working with Providence to establish it as a

formal health network noting that Providence already serves a significant number of members through the Direct Network. With the Board's authorization, efforts are underway to transition Providence into its own health network, enhancing care coordination as well as network structure.

Richard Pitts, D.O., Ph.D, Chief Medical Officer, emphasizing the importance of everyone becoming ambassadors for health, even if they are not healthcare professionals and noted that with the many distractions in the world, it was crucial not to lose focus on pressing local health issues. Dr. Pitts also reviewed the leading cause of death for people aged 15 to 54 in Orange County and noted that drug overdoses were the number one cause of death. This underscores the urgent need to address behavioral health, which is often a root cause of substance abuse.

Michael Hunn, Chief Executive Officer, asked MAC member Kim Goll, President/Chief Executive Officer of First 5 OC, to speak briefly about the anticipated impacts of recent legislation, including HR 1, the state budget, and the upcoming end of continuous Medi-Cal eligibility for children ages 0–5, effective January 1, 2026.

Ms. Goll emphasized the urgency of outreach to families regarding re-enrollment in Medi-Cal. She stressed that many children would remain eligible but may lose coverage due to the administrative process, leading to missed well-child visits and screenings. She described the situation as a "domino effect," where families unaware of the changes may struggle with paperwork and accessing care. First 5 OC is mobilizing its workforce, including home visits and pediatric clinic staff, to support families through this transition. Ms. Goll also noted the challenge of declining tobacco tax revenue, which funds First 5 OC, and invited everyone to collaborate and come up with ideas to enhance outreach efforts.

Mr. Hunn reiterated the importance of reminding families that, starting in 2026, they must reapply for Medi-Cal during their eligibility month through the County of Orange Social Services Agency. He acknowledged that many families may not understand the new requirements and highlighted efforts to raise awareness, including a recent front-page article in the Orange County Register about declining well-child visits and immunizations.

Mr. Hunn then asked Dr. Jacob Sweidan, Health Network Representative on the PAC to share his concerns about the declining visits and Dr. Sweidan discussed trends from his pediatric practice, including a 60–70% drop in patient volume. He discussed the increasing vaccine hesitancy, partly fueled by misinformation in the media and described how fear of Immigration and Customs Enforcement (ICE) deters families from attending appointments, and how some families are requesting exemption letters for school immunizations. Dr. Sweidan emphasized the need for public messaging to reassure families that clinics are safe and open, and that immunizations are critical. Dr. Sweidan also noted the strain on his staff, who are working hard to maintain contact with families and discourage unnecessary ER visits.

Michael Hunn concluded his report by discussing a recent back-to-school event where 750 bike helmets were distributed to address rising head injuries from e-bike accidents. He also noted the need to pursue grants that support Medi-Cal re-enrollment navigation and promised future updates on budget and legislative impacts, particularly as more data becomes available in October.

The members of the MAC and PAC appreciate the opportunity to update the Board on their current activities.

REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

August 7, 2025

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on August 7, 2025, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person, and via Zoom webinar as allowed for under Assembly Bill 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under View Past Meeting Materials. Chair Isabel Becerra called the meeting to order at 2:00 p.m., and Director Catherine Green led the Pledge of Allegiance.

ROLL CALL

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

(All Board members participated in person)

Members Absent: Veronica Kelley (non-voting)

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

The Clerk noted for the record that staff would like to reorder the agenda to hear Closed Session immediately after the Consent Calendar and would like to continue Agenda Item 11 to the September Board meeting to allow for additional amendments. In addition, staff would also like to reorder the agenda, starting in the Reports/Discussion Item section, to hear Agenda Items 13, 14, 17, and 18 and then hear Agenda Items 15, 16 and 19.

PRESENTATIONS/INTRODUCTIONS

None.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

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

Mr. Hunn briefly reviewed the Fast Facts, noting that CalOptima Health currently serves approximately 904,213 individuals. He reported that CalOptima Health's Key Financial Indicators, which are: operating income/(loss); non-operating income/(loss); bottom line (change in net assets); medical loss ratio ; and administrative loss ratio, are all showing green, meaning they are within budget.

CalOptima Health's Board-designated reserves are a little over $1.5 billion; its statutory designated reserves are $132.4 million; its capital assets are $98.6 million; its unspent balance of allocated resources committed by the Board are $404.5 million; its unspent balance of Board-approved provider rate increases

is $315.7 million; and its unallocated resources are $265.7 million. Mr. Hunn noted that CalOptima Health's total net assets are currently $2.8 billion.

Mr. Hunn also added that the usual information in the Fast Facts – the personnel summary, provider network data, treatment authorizations, and member demographics – are in the meeting materials. He thanked all the staff who helped to prepare the Fast Facts report, which allows the Board and the public to see CalOptima Health's overall performance.

Mr. Hunn highlighted a few items from his report and wanted to point out that despite recent changes and votes affecting both the federal and state budgets, it is important for CalOptima Health members to understand that there have been no changes to medical benefits in California. Access to services, eligibility requirements, and the ability to apply for Medi-Cal through BenefitsCal.com remain fully intact. CalOptima Health wants to reassure members that their healthcare access has not been impacted.

To reinforce this message, CalOptima Health has launched a targeted communication campaign, sending over 300,000 text messages to members. These messages have also reached its community-based and network partners to ensure that everyone involved in member care is informed. The core message is consistent: there has been no change in access to medical or behavioral health services.

Additionally, CalOptima Health is promoting telehealth options for those who may be hesitant to visit clinics or doctor's offices in person. By visiting caloptima.org, members can find a list of providers offering telehealth services for both medical and behavioral health needs. This approach builds on the successful remote care strategies used during the COVID-19 pandemic, ensuring continued access to care in a safe and convenient way.

Mr. Hunn emphasized the importance of ensuring that individuals and families, including children, adults, and seniors, continue to pick up their prescriptions or arrange for them to be delivered directly to their homes. Access to necessary medications is critical, and CalOptima Health is encouraging members to take advantage of mail-order options to maintain their health and well-being.

To prevent confusion caused by recent media coverage, CalOptima Health is amplifying this message across multiple platforms. Its goal is to make sure members clearly understand that there have been no changes to medical benefits or services. Access remains the same, and individuals can still apply for Medi-Cal through BenefitsCal.com.

CalOptima Health is working closely with community-based organizations, hospitals, and clinics to reinforce this message consistently. These partnerships are essential in helping CalOptima Health reach members where they are and ensure they receive accurate, reassuring information. CalOptima Health will continue this outreach effort to support its members and eliminate any uncertainty about their healthcare access.

Mr. Hunn updated the Board on a recent back-to-school event. This past weekend, a highly successful back-to-school event was held at the Westminster Civic Center, with 42 community partners participating and 82 CalOptima Health staff members volunteering. The event drew a large crowd, with entrance counters recording approximately 3,600 attendees, though the actual number was likely higher due to multiple entry points. The event featured a wide range of free resources and services, including the distribution of 2,000 backpacks, 750 bike helmets, over 600 boxes of food, 2,000 popsicles, and numerous taco meals. Additionally, 1,000 hygiene kits were handed out, and all appointments for dental,

vision, medical, and vaccine services were fully booked. Free haircuts were also offered, with 10 children served at a time.

A particularly heartwarming highlight was the donation of 4,000 pairs of shoes by the H4H Foundation—all of which were given away. Seeing children joyfully receive their new shoes was a powerful reminder of the event's impact. The event not only provided essential supplies but also offered emotional relief to families. One mother shared with First 5 Orange County that this was the first time she had left her home in weeks, and she was grateful to receive everything her children needed for school, which was something she otherwise could not afford.

The back-to-school event underscored the importance of community outreach in supporting the health, mental well-being, and preparedness of children as they return to school. The presence of trusted community partners played a crucial role in making families feel safe and supported. Despite ongoing misinformation and fear in the community, particularly around access to care. The event demonstrated the power of trusted relationships and collaborative efforts.

Mr. Hunn thanked the Board for its continued support.

ADVISORY COIMMITTEE UPDATES

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

Christine Tolbert, MAC Chair, provided an overview of the recent activities of the MAC and PAC. Ms. Tolbert noted that the MAC and PAC each formed separate ad hoc committees to review their respective seat compositions. This action was taken in response to an updated notice from the Department of Health Care Services, which requires the MAC to expand and ensure broader representation from specific agencies and populations. Both ad hoc committees have since met and developed recommendations that will be presented at the upcoming regular committee meetings.

The recommended changes to the MAC composition include proposed changes to seat titles, clearer definitions of roles, and distinctions between the populations each seat is intended to represent on the MAC. The committees are fortunate to have highly experienced members with deep ties to the Orange County community, and the ad hoc groups have worked to leverage that expertise in shaping a more representative and effective committee structure.

At the upcoming meeting on August 14, the PAC ad hoc committee will not propose any changes to its composition but will request approval for a new physician representative. That request will be brought to the Board for final approval at the September Board meeting. In addition to the seat composition discussions, the agenda for next week's MAC and PAC meeting includes updates on grievances and appeals, the Member Population Health Needs Assessment, the annual Cultural and Linguistics report, and executive updates from CalOptima Health.

Ms. Tolbert thanked Cheryl Simmons for her support in facilitating the ad hoc committee discussions and to the ad hoc committee members for their thoughtful contributions.

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PUBLIC COMMENTS

- Dr. Kimberly Lynch, AltaMed Health Services: Oral report regarding Agenda Item 13.
- Dr. Vaneesh Soni, Welbe Health: Oral report regarding Agenda Item 15.
- Ms. Angie Manetti, Campbell Strategic Advisory: Oral report on behalf of Innovage regarding Agenda Item 15.

CONSENT CALENDAR

3. Minutes

a. Approve Minutes of the June 5, 2025, Regular Meeting of the CalOptima Health Board of Directors
b. Receive and File Minutes of the March 12, 2025, Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

4. Approve New Appointments and Reappointments to the CalOptima Health Whole-Child Model Family Advisory Committee

5. Approve Reappointments and Appointments to the CalOptima Health Board of Directors' Member Advisory and Provider Advisory Committees

6. Authorize and Direct Execution of Amendments to the Companion Contract and the Primary Contract with the California Department of Health Care Services for the CalOptima Health Program of All-Inclusive Care for the Elderly

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

8. Authorize the Chief Executive Officer to Negotiate and Execute a Contract with OpenText for a Cloud-based Faxing Solution

Vice Chair Sarmiento had a few questions regarding contracting without going through a competitive bid process, especially considering the contract is for one year only.

Yunkyung Kim, Chief Operating Officer, responded to Vice Chair Sarmiento, noting that CalOptima Health's current facsimile product is outdated and the vendor is RightFax. She noted that CalOptima Health needs a facsimile product, which is heavily relied upon by CalOptima Health's hospitals and physicians' offices. RightFax has an updated cloud-based solution that is secure and will also convert the older current technology for a much better price than a new vendor would be able to offer. Ms. Kim also noted that this would be a multi-year contract and that this current action is for this fiscal year, which is covered in the Fiscal Year budget 2025-2026. Costs for subsequent contract years will be budgeted in subsequent years' budgets going forward.

9. Approve Actions Related to Covered California Administrative Services Agreements

10. Approve Modifications to the CalOptima Health Capitalization Policy

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11. Approve Modifications to Policy GA.5004: Travel and Other Reimbursable Expenses
This item was continued to the September 4, 2025, Board meeting.

12. Receive and File:

a. May and June 2025 Financial Summaries
b. Compliance Report
c. Government Affairs Reports
d. CalOptima Health Community Outreach and Program Summary
e. Fiscal Year 2025 Strategic Plan Performance Executive Status Report April - June 2025

Action: ***On motion of Vice Chair Sarmiento, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 3 through 12, minus Agenda Item 11, as presented. (Motion carried 9-0-0; Director Kelley (non-voting) absent)***

As the Clerk noted at the top of the meeting, the Board will hear Closed Session immediately after the Consent Calendar.

CLOSED SESSION
The Board adjourned to Closed Session at 2:35 p.m. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Government Code section 54956.9(d)(4): 2 cases.

The Board returned to Open Session at 4:19 p.m., and the Clerk re-established a quorum.

ROLL CALL
Members Present: Isabel Becerra, Chair; Supervisor Vicente Sarmiento, Vice Chair; Maura Byron; Supervisor Doug Chaffee; Blair Contratto; Norma García Guillén; Catherine Green, R.N.; Brian Helleland; Jose Mayorga, M.D.

(All Board members participated in person)

Members Absent: Veronica Kelley (non-voting)

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

As the Clerk noted at the top of the agenda, the agenda is being reordered to hear Agenda Items 13, 14, 17 and 18.

Chair Becerra noted for the record that she will not be participating in Agenda Items 13, 14, 17 and 18 due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and will leave the room during the discussions and votes. Chair Becerra passed the gavel to Vice Chair Sarmiento.

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REPORTS/DISCUSSION ITEMS

13. Select and Enter into Grant Agreement with Street Medicine Provider

Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and left the room during the discussion and vote. Director Mayorga did not participate in this item due to his role as Senior Vice President and Chief Quality Officer at AltaMed Health Services and left the room during the discussion and vote.

The Board heard public comment on this item as indicated under the Public Comments section above.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1) Ratified CalOptima Health issuing a Request for Proposal for the street medicine provider for the city of Santa Ana; 2) Approved the Request for Proposal Evaluation Committee recommendation for the street medicine provider for the city of Santa Ana; 3) Changed the funding source for the two-year grant agreement with the selected street medicine provider by: a.) Cancelling the March 6, 2025, Board of Directors action to appropriate up to $4.3 million from existing reserves; and b.) Appropriating up to $4.3 million from the Intergovernmental Transfer balance resulting from a June 5, 2025, Board of Directors action; 4) Authorized the Chief Executive Officer or designee to execute a two-year grant agreement in an amount not to exceed $4.3 million in aggregate to expand CalOptima Health's Street Medicine Program with awarded Medi-Cal street medicine provider; and 5) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose. (Motion carried 7-0-0; Chair Becerra and Director Mayorga recused; Director Kelley (non-voting) absent)***

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

Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and left the room during the discussion and vote. Director Contratto did not participate in this item due to her role as Chief Strategy Officer at Be Well OC and left the room during the discussion and vote. Director Mayorga did not participate in this item due to his role as Senior Vice President and Chief Quality Officer at AltaMed Health Services and left the room during the discussion and vote.

Director Byron provided an update on behalf of the Grants Management Ad Hoc Committee before the Board proceeded with decisions regarding the Grant Policy and related matters. Director Byron noted that over the past few years, CalOptima Health has invested over $300 million into the community to strengthen the provider network and improve access to essential medical and social services. She noted that in March 2025, the Board created an ad hoc committee to evaluate the evolution of CalOptima Health's grant-making program and to support management in ensuring its sustainability and alignment with community needs.

Since its formation, the ad hoc committee – comprised of Director Cathy Green and Director Byron – has met regularly and observed significant progress. CalOptima Health has been actively learning and applying best practices in grant-making, with input from legal advisors, consultants, and philanthropic experts. A key development has been the establishment of a governance framework, including the

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creation of an Executive Community Investment Committee and a centralized Grants Management Department. The Grants Management Department, led by experienced professionals Kelly Bruno-Nelson and Danielle Cameron, ensures consistency and oversight in all grant-related activities.

Additionally, CalOptima Health has refined its grant-making policies and procedures. Management has presented updates to both the ad hoc committee and the full Board, including the introduction and approval of a grant auditing policy. The committee also reviewed a comprehensive report summarizing active and recently closed grants. To further enhance consistency, CalOptima Health has adopted universal grant templates, streamlining internal and external processes. Director Byron expressed anticipation for the Board's discussion on the committee's latest recommendations.

Danielle Cameron, Senior Director, Grant Programs, presented an overview of CalOptima Health's progress in developing a transparent, thoughtful, and impactful community grant-making process. Over the past few months, CalOptima Health has made significant strides in establishing policies, procedures, and oversight practices to support this work. Central to these efforts is the Strategic Community Investment Committee – an internal body composed of Chief-level and Executive Director-level leaders from key departments. This committee meets monthly to review current funding opportunities, assess grant portfolios, and recommend new funding initiatives for the Board's consideration.

In addition to this oversight, CalOptima Health has launched a dedicated Grants Management Department to provide consistent support across all departments involved in grant-making. Led by Executive Director Kelly Bruno-Nelson, who has decades of experience in philanthropy and nonprofit leadership, the department is staffed by a five-person team. This includes the Senior Director Danielle Cameron and three program managers – Sarah Nance, Gary Taylor, and Jasmine Awadallah – each contributing unique expertise in grant management, community programming, and evaluation. Together, the team manages nearly 200 active grants valued at over $300 million.

This department oversees the entire grant life cycle, from designing funding opportunities and soliciting applications to awarding grants, processing payments, and monitoring progress. A significant portion of the team's time is dedicated to monitoring active grants, which includes reviewing reports and budgets, conducting check-ins, and making site visits. The team also ensures thorough documentation of grant outcomes and collaborates with internal departments like finance, contracting, and auditing to maintain accountability and transparency.

To support both internal staff and grantees, the department has developed a suite of standardized templates and tools. These include notices of funding opportunities, high-level monitoring reports, narrative and budget progress reports, budget reallocation forms, and site visit reports. Additional templates cover email communications, performance improvement plans, and close-out letters. These tools ensure consistency and clarity throughout the grant process.

In recent months, the department has been integrating grant portfolios from across the organization to centralize and standardize administrative support. By the end of the fiscal year, all grants will follow a consistent process, including standardized agreements, scopes of work, measurable outcomes, and monitoring procedures. This unified approach reflects CalOptima Health's commitment to ensuring that all community investments lead to increased access, expanded care opportunities, and stronger support for CalOptima Health members.

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After hearing an update from the Grants Management Ad Hoc Committee and staff's presentation, the Board took the following action.

Action: ***On motion of Director Byron, seconded and carried, the Board of Directors approved the revised CalOptima Health Policy AA.1400: Grant Management, effective August 7, 2025. (Motion carried 6-0-0; Chair Becerra and Directors Contratto and Mayorga recused; Director Kelley (non-voting) absent)***

17. Ratify Amendment to Grant Award Agreement with Coalition of Orange County Community Health Centers for Population Health and Value-Based Care Transformation

Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and left the room during the discussion and vote. Director Mayorga did not participate in this item due to his role as Senior Vice President and Chief Quality Officer at AltaMed Health Services and left the room during the discussion and vote.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors ratified the grant amendment with the Coalition of Orange County Community Health Centers for the Population Health and Value-Based Care Transformation to update terms and conditions related to payment, reporting, and other contract provisions. (Motion carried 7-0-0; Chair Becerra and Director Mayorga recused; Director Kelley (non-voting) absent)***

18. Ratify Amendments to the Grant Agreements with CalOptima Health Comprehensive Community Cancer Screening and Support Grantees

Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers and left the room during the discussion and vote. Director Mayorga did not participate in this item due to his role as Senior Vice President and Chief Quality Officer at AltaMed Health Services and left the room during the discussion and vote.

Action: ***On motion of Director Green, seconded and carried, the Board of Directors ratified the amendments to grant agreements with the first round of community grants recipients in the CalOptima Health Comprehensive Community Cancer Screening and Support Program approved on August 1, 2024, that included the following: 1.) Inserted additional measurable objectives that align with the original scopes of work to ensure consistent monitoring across grantees; 2.) Provided a no-cost extension to provide grantees additional time to execute the Program; 3.) Realigned the reporting requirements with the calendar year to provide consistency when evaluating Healthcare Effectiveness Data and Information Set measures and screening rates; 4.) Removed the line item budgets from the grant agreement and instead include terms for managing the budget outside of the agreement; and 5.) Changed the pay schedule to more closely align with the reporting schedule, ensuring grantees are paid on a timely basis and coinciding with demonstration of positive performance against metrics. (Motion carried 7-0-0; Chair***

Becerra and Director Mayorga recused; Director Kelley (non-voting) absent)

Vice Chair Sarmiento passed the gavel back to Chair Becerra.

As the Clerk noted at the top of the agenda, the agenda is being reordered to hear Agenda Items 15, 16 and 19.

15. Approve New CalOptima Health PACE Policy PA.9003: PACE Letters of Support
Director Helleland did not participate in this item due to his role as Chief Executive at Providence/St. Joseph Hospital and left the room during the discussion and vote.

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

After considerable discussion, the Board agreed to continue this item to allow for legal counsel to prepare an overview of possible risks to CalOptima Health if it excludes for-profit PACE centers from operating in Orange County.

Action: ***On motion of Director Garcia Guillen, seconded and carried, the Board of Directors continued this item to allow for legal counsel to prepare an overview of possible risks to CalOptima Health if it excludes for-profit PACE centers from operating in Orange County. (Motion carried 8-0-0; Director Helleland recused; Director Kelley (non-voting) absent)***

16. Authorize Amendments to the CalOptima Health Medi-Cal Fee-for-Service Hospital Services Contracts
Director Helleland did not participate in this item due to his role as Chief Executive at Providence/St. Joseph Hospital and left the room during the discussion and vote.

Action: ***On motion of Vice Chair Sarmiento, seconded and carried, the Board of Directors authorized the Chief Executive Officer, or designee, to execute amendments to the CalOptima Health Medi-Cal Fee-for-Service Hospital Services Contracts, effective October 1, 2025, to update: 1.) Definition for Prior Authorization; 2.) Definition for Utilization Management Program; 3.) Language regarding determination of medically necessary covered services; and 4.) Language related to assignment, assumption, and change of control. (Motion carried 8-0-0; Director Helleland recused; Director Kelley (non-voting) absent)***

19. Ratify Extension of Grant Award Agreement with Mind OC for the Be Well OC Irvine Campus
Director Contratto did not participate in this item due to her role as Chief Strategy Officer at Be Well OC and left the room during the discussion and vote. Director Helleland did not participate in this item due to his role as Chief Executive at Providence/St. Joseph Hospital and left the room during the discussion and vote.

Action: ***On motion of Director Byron, seconded and carried, the Board of Directors ratified the grant amendment that extends the term of the grant***

award agreement with Mind OC for the Be Well OC Irvine campus through December 31, 2025. (Motion carried 7-0-0; Directors Contratto and Helleland recused; Director Kelley (non-voting) absent)

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Director Byron thanked staff, and especially those who contributed to the grants committee, for their dedication and collaboration in aligning CalOptima Health's efforts with best practices. Their hard work and commitment are truly appreciated and continue to make a meaningful impact.

Director Garcia Guillen thanked the staff on the Legislative Ad Hoc Committee and counsel for their swift and thoughtful response in addressing the unauthorized sharing of information involving vulnerable CalOptima Health members and others. Their immediate action in the face of such a critical issue demonstrated a deep commitment to protecting the community.

Director Mayorga thanked staff and his fellow Board members for their dedication and thoughtful contributions to today's agenda. Many of the items discussed required significant time and careful consideration, and their efforts are truly appreciated. CalOptima Health is navigating a particularly important moment in its community, and it is essential to recognize and thank all the community partners, especially the nonprofit organizations working directly on the ground. Their advocacy and strong connections to CalOptima Health play a vital role in ensuring members have access to the care they need.

Supervisor Chaffee thanked staff for all the work that went into the very successful back-to-school event. He also requested a list of current ad hoc committees, including the date they were created, the purpose of each ad hoc committee, and the Board members serving on each ad hoc committee.

Vice Chair Sarmiento thanked the members of the public who came to speak at the meeting today and thanked staff for their hard work and dedication. Reflecting on his time since joining the Board, he recalled expressing a strong desire to see CalOptima Health invest in meaningful efforts to support its members – done thoughtfully and responsibly. Vice Chair Sarmiento commented that he believes the decisions made today reflect that commitment. Vice Chair Sarmiento noted that he is grateful to his fellow Board members for their dedication to being responsible stewards of public funds and for ensuring that CalOptima Health upholds its promise to serve its members with care and integrity.

Vice Chair Sarmiento added that as CalOptima Health moves forward, it must remain mindful of the difficult circumstances many of its members are facing, particularly those it expanded coverage to under the promise of safety and support. Issues like public charge concerns and the unauthorized sharing of sensitive information have created fear and instability in its communities. CalOptima Health is seeing the effects in declining school attendance, reduced public transit use, and avoidance of medical care. Some families have even gone completely underground. This reality adds a new and urgent dimension to CalOptima Health's mission as a public health plan – one it never anticipated but must now embrace.

CalOptima Health must continue to work closely with advocacy groups and community partners to protect and support these vulnerable populations. While CalOptima Health's original intent was to expand access and care, it now carries the added responsibility of ensuring safety and trust. Vice Chair Sarmiento noted that he is proud of the steps that CalOptima Health has taken today and is hopeful that it will continue to rise to the challenge with compassion, diligence, and a deep sense of purpose.

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Director Green thanked Director Byron and the staff for their excellent work on the Grants Ad Hoc Committee. Their leadership and dedication were instrumental in keeping the process on track and moving forward. Meeting every other week and staying committed to the work allowed the ad hoc committee to make meaningful changes, and Director Green truly appreciates the effort and collaboration.

Director Helleland thanked staff, with special appreciation for the Grants Management Team, Kelly Bruno-Nelson and Danielle Cameron, whose leadership on such a serious and important topic was both timely and impactful. Reaching a level of excellence in this work was critical, and they delivered. Director Helleland noted that Ms. Cameron's presentation stood out – not just for its content, but for the passion and dedication she brought to the discipline of grant management. Ms. Cameron's commitment truly came through and made a lasting impression.

Chair Becerra noted in closing that she echoes the thoughtful comments shared by her colleagues and emphasized the core of CalOptima Health's mission – it works for the community and the Medicaid beneficiaries who depend on CalOptima Health. She added that it is CalOptima Health's responsibility to bring its collective expertise but also its compassion, meeting people where they are.

ADJOURNMENT
Hearing no further business, Chair Becerra adjourned the meeting at 5:08 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: September 4, 2025

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CalOptima Health Board Action Agenda Referral

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

Consent Calendar

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

Contact

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

Recommended Action

1. Approve new CalOptima Health Policy CC.1800: Medical Group/Independent Physician Association (IPA) Compensation, effective January 1, 2027.
2. Approve modifications to CalOptima Health Policies FF.3002: Financial Oversight and FF.3003: Minimum Medical Loss Ratio, effective January 1, 2027, for Covered California.

Background

On August 1, 2024, the CalOptima Health Board of Directors (Board) authorized the Chief Executive Officer (CEO) to convene a stakeholder steering committee composed of key external partners and providers to discuss considerations for potential participation in Covered California. CalOptima Health leadership and staff convened the Covered California Stakeholder Steering Committee, which has met on nine separate occasions. On October 3, 2024, the Board directed the CEO to request the Orange County Board of Supervisors (BOS) to amend CalOptima Health's governing ordinance to remove the prohibition on participation in Covered California. On December 5, 2024, the Board approved actions related to Covered California consulting support contracts and associated funding. On January 14, 2025, the BOS unanimously voted to amend the ordinance to allow CalOptima Health's participation in Covered California.

CalOptima Health must obtain approval to operate a Covered California product under its Knox-Keene Act license from the California Department of Managed Health Care (DMHC). Obtaining a Knox-Keene Act license or expanding an existing license is a regulatory filing process that all plans must comply with to offer an individual market health plan. While CalOptima Health is currently licensed with DMHC for the OneCare Medicare product, CalOptima Health must submit a filing to expand its current Knox-Keene Act license to participate in the individual market. As a first step in this process, CalOptima Health participated in a pre-filing conference with DMHC on February 25, 2025, and submitted its filing to the DMHC to participate in Covered California on June 16, 2025.

Discussion

The DMHC filing process is a multi-phased process that CalOptima Health must complete by early 2026 to obtain the proper approvals to operate an individual market health plan. The process requires the

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submission of at least 89 supporting exhibits that demonstrate compliance with the requirements of the Knox-Keene Act.

Several of the documents that must be submitted to DMHC are policies and procedures that demonstrate compliance with statutory and regulatory requirements. Staff has evaluated the policies and procedures that are needed to demonstrate compliance.

New CalOptima Health Policy CC.1800: Staff recommends approval of CC.1800: Medical Group/Independent Physician Association (IPA) Compensation, a new policy which describes the financial mechanisms for how CalOptima Health's Medical Groups/IPAs will receive funding for participation in the Covered California line of business in exchange for delegated risk. Financial provisions contained within the policy include:

- Base capitation rates stratified by age/gender/metal tier bands;
- Interim relative risk scores;
- Capitation withhold;
- Annual one-time true-up and settlement, inclusive of adjustments for:
    - Final relative risk;
    - Risk adjustment transfer payment; and
    - Shared risk pool settlement.

Modifications to CalOptima Health Policies FF.3002 and FF.3003: Staff recommends modifications to two (2) existing policies to align with Covered California requirements.

- FF.3002: Financial Oversight: The Board last approved modifications to this policy on June 4, 2020. The Policy outlines the process by which CalOptima Health monitors a Health Network's financial position and financial solvency reserves. The proposed changes include application of the policy and its requirements to the Covered California line of business beginning January 1, 2027.
- FF.3003: Minimum Medical Loss Ratio: The Board last approved modifications to this policy on May 7, 2002. The Policy defines the minimum acceptable Health Network Medical Loss Ratio (MLR) included as part of a Health Network's participation requirement with CalOptima Health. The proposed changes include application of the policy and its requirements to the Covered California line of business beginning January 1, 2027, addition of language on physician distribution payments and allocation methodologies, and updates to MLR template description.

Fiscal Impact

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

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Rationale for Recommendation

Approval of the new policy and revisions to existing policies will support CalOptima Health's application to expand its Knox-Keene Act license to operate an individual market plan.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Health Policy CC.1800: Medical Group/Independent Physician Association (IPA) Compensation
2. CalOptima Health Policy FF.3002: Financial Oversight
3. CalOptima Health Policy FF.3003: Minimum Medical Loss Ratio

/s/ Michael Hunn *08/28/2025*

Authorized Signature **Date**

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Policy:	CC.1800
Title:	**Medical Group/Independent Physician Association (IPA) Compensation**
Department:	Finance
Section:	Accounting
CEO Approval:	*/s/*
Effective Date:	01/01/2027
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250904 BOD Review Only

I. PURPOSE

This policy sets forth CalOptima Health's compensation for Medical Group/Independent Physician Associations (IPAs) under the Covered California program.

II. POLICY

A. CalOptima Health shall pay a Medical Group/IPA Monthly Capitation in accordance with the Contract for Health Care Services and provisions set forth in this policy.

1. Monthly Capitation will be based on the number of Members enrolled with the Medical Group/IPA, using a capitation rate which shall be based on a Per Member Per Month (PMPM) fee, determined by age, sex, and benefit level of Members assigned, and adjusted by the Interim Relative Risk Factor.

   a. The Interim Relative Risk Factor shall be calculated by taking the most recent year Member's Covered CA Final Relative Risk Factor where available and,

   b. For new Members who do not have a Final Relative Risk Factor from the most recent year's Annual One-Time True-Up and Settlement, a factor of 1.0 shall be used. At the launch of the Covered California program, all Medical Group/IPAs will have Interim Relative Risk Factors of 1.0 as no experience will be available.

   c. Interim Relative Risk Factors will be calculated independently for each age, sex, and benefit level rate.

2. A ten percent (10%) Capitation Withhold shall be applied to Medical Group/IPA Monthly Capitation to be used for offsetting any net financial deficits in the Annual One-Time True-Up and Settlement.

B. CalOptima Health shall perform an Annual One-Time True-Up and Settlement.

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1. Net losses attributable to a Medical Group/IPA from the Annual One-Time True-Up and Settlement shall not exceed the Capitation Withhold collected from the Medical Group/IPA Monthly Capitation for the time period from which it was collected. Excess net losses will not be carried over to future time periods.

2. The Annual One-Time True-Up and Settlement will be performed only once and between CalOptima Health's receipt of all final risk transfer settlement data and reports from Covered California and December 31 following each program calendar year.

3. In the event of a mid-year termination of a Medical Group/IPA as participating provider in Covered California, any return of Capitation Withholds collected along with the Annual One-Time True-Up and Settlement will be calculated at the same time as ongoing Medical Group/IPA providers in the following calendar year as described in section II.B.2.

4. The Annual One-Time True-Up and Settlement will consist of three (3) financial calculations:

    a. The prior year's capitation will be recalculated using Final Relative Risk Factors using eligible and qualified claims and Encounter data accepted by Covered California before the risk adjustment deadline. The difference between paid and recalculated capitation will be applied towards the Annual One-Time True-Up and Settlement.

    b. CalOptima will apportion to each Medical Group/IPA a share of the Risk Adjustment Transfer Payment (RATP) as determined by Covered California. The share will be based on the difference between Expected RATP and Actual RATP expressed as a percentage of plan premium dollars. The percentage difference (*i.e.*, Actual RATP minus Expected RATP) will be applied to the recalculated capitation as determined in section II.B.4.a.

        i. Expected RATP will be based on the unweighted most recent two (2) years' experience at the plan level. In the absence of historical information, a qualified actuary will estimate Expected RATP for those years.

        ii. RATP sharing will be limited to plus or minus five percent (±5%) of the Medical Group/IPA recalculated capitation from section II.B.4.a.

        iii. The final RATP sharing amount will be applied towards the Annual One-Time True-Up and Settlement.

    c. CalOptima Health shall establish a Shared Risk Pool in accordance with the Contract for Health Care Services and the terms and conditions of this policy.

        i. Funding to the Shared Risk Pool will be based on the number of monthly Members enrolled with a Medical Group/IPA, using a capitation rate which shall be based on a PMPM fee, determined by age, sex, and benefit level of Members assigned, and adjusted by the applicable Final Relative Risk Factor and then further adjusted by the RATP sharing percentage from section II.B.4.b.

        ii. Shared Risk Expenses shall include claims and capitation paid for Shared Risk Services provided to Members assigned to the Medical Group/IPA at a rate established in the Contract for Health Care Services.

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iii. CalOptima Health shall institute Stoploss Protection to pool certain costs above a threshold of two hundred fifty thousand dollars ($250,000) per Member per calendar year. Shared Risk Services above the threshold will count toward Shared Risk Expenses at twenty percent (20%) of the actual cost. The Stoploss Protection threshold shall not be prorated for any partial year eligibility of the Member or partial year participation of the Medical Group/IPA.

iv. Shared Risk Expenses will be subtracted from the Shared Risk Pool Budget to determine the surplus or deficit.

v. Fifty percent (50%) of the surplus or deficit shall be applied towards the Annual One-Time True-Up and Settlement.

C. CalOptima Health may recoup any amounts it identifies as improperly paid to a Medical Group/IPA by an offset to a following Monthly Capitation payment.

D. If a Medical Group/IPA identifies an overpayment of Monthly Capitation, the Medical Group/IPA shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified and shall notify CalOptima Health's Accounting Department, in writing, of the reason for the overpayment. CalOptima Health shall coordinate with the Medical Group/IPA on the process to return the overpayment.

E. A Medical Group/IPA shall report any and all disputes related to payment or enrollment, except as specified in Section II.D. of this policy, in writing, to CalOptima Health's Accounting Department within ninety (90) calendar days after receipt of payment. Failure to dispute within the established time frame indicates acceptance by the Medical Group/IPA and a waiver of its right to dispute.

III. PROCEDURE

A. Capitation Payment

1. CalOptima Health shall pay a Monthly Capitation payment to only one (1) Medical Group/IPA for enrolled Members.

   a. The Medical Group/IPA receiving the Monthly Capitation shall ensure compliance with CalOptima Health's financial security requirements as set forth in CalOptima Health Policy FF.3002: Financial Oversight.

   b. A Medical Group/IPA shall handle subsequent payments internally for any sub-capitation, or other subcontractor arrangements.

2. CalOptima Health shall pay the Monthly Capitation on, or about, the fifteenth (15th) calendar day of the month to which the Monthly Capitation applies.

3. CalOptima Health shall pay the Monthly Capitation rate for Members on a daily prorated basis with routine adjustments for Retroactive Terminations of Eligibility up to six (6) months. The Capitation Payment shall be for the current month and adjustments for the prior six (6) months (seven (7) total months). In the event Retroactive Terminations of Eligibility implicate potential refunds or recoupments in excess of this timeframe, such actions will be evaluated on a case-by-case basis.

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4. Within three (3) working days of check issuance, the CalOptima Health Information Technology (IT) Department shall post a Member-level detail report to CalOptima Health's Secure File Transfer Protocol (SFTP) site, which the Medical Group/IPA may use to reconcile the Monthly Capitation payment.

B. Quarterly Shared Risk Pool Reporting

1. Within forty-five (45) calendar days following the end of each quarter, CalOptima Health shall provide a Medical Group/IPA with a written report of the status of the Shared Risk Pool.

2. The report shall include:

a. An annualization of the aggregate amount of the Shared Risk Budget and Shared Risk Expenses for all months to date during that calendar year; and

b. An estimate of the projected Shared Risk Pool deficit or surplus at the end of the program calendar year.

C. Annual Shared Risk Pool Reconciliation and Settlement

1. No sooner than CalOptima Health's receipt of all final risk transfer settlement data and reports from Covered California and no later than December 31 of the following calendar year, CalOptima Health shall provide the Medical Group/IPA with an Annual Shared Risk Program Report. The Annual Shared Risk Program Report shall show reconciliation of allocations, deposits, expenses, and disbursements for the immediately preceding calendar year, and the final status of the Shared Risk Pool.

a. CalOptima Health shall calculate the Shared Risk Budget for the annual reconciliation in accordance with Section II.B.4.c of this policy. The Shared Risk Budget for the calendar year shall include:

i. The Hospital Budget Capitation Allocation for Members assigned to the Medical Group/IPA within that calendar year, including any retroactivity adjustments up to the time of settlement; and

ii. Stoploss Protection pooling charges or reductions (if any) for dates of service within that calendar year.

b. CalOptima Health shall calculate Shared Risk Expenses for the annual reconciliation in accordance with Section II.B.4.c of this policy. Shared Risk Expenses for the calendar year shall include:

i. Claims and capitation for Shared Risk Services for dates of service within that calendar year and paid up to the time of settlement;

ii. Stoploss Protection expense reductions.

c. CalOptima Health shall reduce Shared Risk Expenses for the calendar year by:

i. Any applicable copayments, deductibles, or third-party payments collected by CalOptima Health or a provider for Shared Risk Services provided to Members

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assigned to the Medical Group/IPA during that calendar year up to the time of settlement; and

ii. Any recoveries, including overpayments, for dates of service within that calendar year related to Shared Risk Services provided to Members assigned to the Medical Group/IPA and received up to the time of settlement.

2. CalOptima Health shall compute the annual Shared Risk Pool surplus or deficit by deducting the Shared Risk Expenses from the Shared Risk Budget for the calendar year.

a. If CalOptima Health determines that the Shared Risk Pool is in surplus, the Annual Shared Risk Program Report shall reflect an amount creditable to the Annual One-Time True-Up and Settlement equaling fifty percent (50%) of that surplus.

b. If CalOptima Health determines that the Shared Risk Pool is in deficit, the Annual Shared Risk Program Report shall reflect that CalOptima Health shall deduct from the Annual One-Time True-Up and Settlement an amount equaling to fifty percent (50%) of that deficit.

3. If, upon review of the Annual Shared Risk Program Report, a Medical Group/IPA objects to the calculations and determination, the Medical Group/IPA may complete and submit the Risk Pool Claims Objection Form along with any supporting documentation to the CalOptima Health Accounting Department within thirty (30) calendar days from the date of receipt of the Annual Shared Risk Program Report.

a. If CalOptima Health does not receive any written objection from the Medical Group/IPA within thirty (30) calendar days of receipt of the Annual Shared Risk Program Report, such settlement shall be considered final.

b. If CalOptima Health receives written notice of objection from the Medical Group/IPA within the objection period, CalOptima Health shall re-evaluate its calculations based on additional documentation provided by the Medical Group/IPA and provide a final Annual Shared Risk Program Report to the Medical Group/IPA within forty-five (45) calendar days after receipt of the written objection.

D. Calculation of the Final Relative Risk Factor

1. As specified in section II.B.4.a, CalOptima Health will calculate a Final Relative Risk Factor to recalculate the prior year's total Monthly Capitation as part of the Annual One-Time True-Up and Settlement.

2. The Final Relative Risk Factor will be calculated by:

a. Creating a database of the raw risk scores from the HHS-HCC model or its successor as provided by Covered California for the purposes of computing the plan's RATP.

b. Normalize the Member raw risk scores segmented by age, sex, and metal tier PMPM rate for the program calendar year.

c. The Medical Group/IPA's Final Relative Risk score for each age, sex, and metal tier PMPM rate will be calculated by taking that applicable Member month weighted average of

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normalized Member risk scores.

E. Calculation of the Interim Relative Risk Factor

1. As specified in section II.A.1, CalOptima Health will calculate for each month an Interim Relative Risk Factor as part of the Monthly Capitation payment process.

2. CalOptima Health shall only compute the current month's Interim Relative Risk Factor, *i.e.* there will be no restatement of Interim Relative Risk Factors for prior months due to retroactivity of Member eligibility.

3. Interim Relative Risk Factors will be based on the most recent year's Annual One-Time True-Up and Settlement Final Relative Risk Factors for Members that have ongoing eligibility for each Monthly Capitation calculation.

4. For Members without a Final Relative Risk Factor in the most recent Annual One-Time True-Up and Settlement, a factor of 1.0 shall be used.

5. CalOptima Health will apply actuarial methods to limit the effect of outlier Member risk scores.

6. CalOptima Health shall normalize Interim Relative Risk Factors such that the overall average is 1.0 for each age, sex, metal tier group PMPM rate.

7. CalOptima Health will supply Medical Group/IPA specific risk adjusted age, sex, metal tier group PMPM rates to CalOptima Health IT in time for each calculation of the Medical Group/IPA Monthly Capitation payment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract for Health Care Services
B. CalOptima Health Contract with Covered California
C. CalOptima Health Policy FF.3002: Financial Oversight

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1800	Medical Group/IPA Compensation	Covered California

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IX. GLOSSARY

Term	Definition
Actual Risk Adjustment Transfer Payment (Actual RATP)	The actual amount of Risk Adjustment Transfer Payment expressed as a percentage of premium dollars.
Annual One-Time True-Up and Settlement	The annual process that completes final payment for the previous calendar year's Medical Group/IPA compensation. The process consists of recalculating and reconciling capitation using the Final Relative Risk Factors, applying Risk Adjustment Transfer Payment (RATP) sharing, and the Medical Group/IPA's share of the calculated shared risk surplus or deficit.
Capitation Withhold	The amount withheld from Monthly Capitation and used to absorb net recoupments as calculated from the Annual One-Time True-Up and Settlement.
Contract for Health Care Services	For the purposes of this policy, the written instrument between CalOptima Health and Medical Group/IPA for the purpose of providing delegated services to assigned Members. Contract shall include any Memoranda of Understanding entered into by CalOptima Health that is binding on the Medical Group/IPA; DMHC All Plan and Policy Letters; other regulatory agencies and authorities; and Contract Interpretation.
Covered California	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State
Encounter	Any unit of Covered Services provided to a Member by a Medical Group/IPA regardless of Medical Group/IPA reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Expected Risk Adjustment Transfer Payment (Expected RATP)	Anticipated Risk Adjustment Transfer Payment expressed as a percentage of total premium dollars.
Final Relative Risk Factor	A concurrent risk adjustment factor as determined by CalOptima Health that approximates population acuity differences. The factors are then normalized to an overall average of 1.0 for the applicable population and time period. The Final Relative Risk Factor is used during the Annual One-Time True-Up and Settlement.
Medical Group/Independent Physician Association (IPA)	A physician group or independent physician association under a shared risk agreement that contracts with CalOptima Health to provide Covered Services to Members assigned to that Medical Group/IPA
Hospital Budget Capitation Allocation	The amount equal to the Shared Risk Budget funding rate (PMPM) set forth in the contract multiplied by the number of Members assigned to the Medical Group/IPA.
Interim Relative Risk Factor	A projected concurrent risk adjustment factor as determined by CalOptima Health that approximates population acuity differences. The factors are normalized to an overall average of 1.0 for the applicable population and time period. This Interim Relative Risk Factor is used to pay Monthly Capitation until the Final Relative Risk Factor has been determined.

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Term	Definition
Member	An individual enrolled in a CalOptima Health program.
Monthly Capitation	The monthly amount paid to a Medical Group/IPA by CalOptima Health for delivery of covered services to Members, which is determined by multiplying the applicable Capitation Rate by a Medical Group/IPA's monthly enrollment based upon benefit level, age, and sex; further adjusted by the Historical Relative Residual Risk Factor and then reduced by the Capitation Withhold.
Retroactive Terminations of Eligibility	A determination that a Member, as of a specified date in the past, is no longer eligible for benefits under the Covered California program.
Risk Adjustment Transfer Payment (RATP)	The annual calendar year retrospective risk adjustment between health plans that applies to Covered California.
Shared Risk Budget	The total amount that CalOptima Health allocates to the Shared Risk Pool to pay for Shared Risk Services as set forth in the DOFR of the contract.
Shared Risk Expenses	Includes: 1. Amounts paid for Shared Risk Services provided to Members assigned to the Medical Group/IPA; 2. Stoploss Protection expense reductions.
Shared Risk Pool	The risk sharing program, under which the risk for the provision of Shared Risk Services to Members is shared and allocated between CalOptima Health and Medical Group/IPA.
Shared Risk Services	Covered benefits as set forth in the Contract for Health Care Services DOFR subject to a Shared Risk Pool.
Stoploss Protection	A reduction to Shared Risk Expenses in the case of catastrophic Member costs. Stoploss Protection reductions are based on the Shared Risk Expenses exceeding a specified threshold per member per year. Costs above the threshold are reduced to a specified percentage.

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Policy:	FF.3002
Title:	**Financial Oversight**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	07/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy outlines the process by which CalOptima monitors a Health Network's financial position and financial security reserves to ensure contract compliance and financial integrity.

II. POLICY

A. The requirements set forth in this policy apply to Medi-Cal and Covered California.

~~A.~~B. CalOptima Health shall conduct Health Network financial reviews and periodic Focused Reviews as it deems necessary. CalOptima Health shall monitor a Health Network's financial position to promote:

1. Access to quality care for Members enrolled in the Health Network;
2. Appropriate and timely payment to Providers that render Covered Services to Members enrolled in the Health Network;
3. Financial integrity of CalOptima Health and its contractors; and
4. Financially prudent utilization of Capitation revenues received from the State of California.

~~B.~~C. Pursuant to the Contract for Health Care Services, CalOptima Health shall ensure that a Health Network complies with Financial Solvency Reserve requirements.

1. Financial Security Reserves - Each entity contracted as a Primary Physician Group, Primary Hospital, or Shared Risk Group (SRG) shall establish and maintain financial security reserves in the form of time certificates of deposit, irrevocable standby letters of credit, or surety bonds naming CalOptima Health as beneficiary, equal to fifty thousand dollars ($50,000) plus a minimum of twenty-five percent (25%) of one (1) month's average Capitation Payment, typically computed at the end of each quarter. CalOptima Health may require a greater amount based upon its assessment of the operational readiness and financial condition of the Primary Physician Group, Primary Hospital, or SRG. If the entity meets the fifty thousand dollars ($50,000) element of the financial security reserve requirement for participation as a contract

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holder with CalOptima Health for Medi-Cal, OneCare, or Covered California Members, the entity shall be deemed to have met the fifty -thousand dollars ($50,000) element of the financial security reserve requirement for ~~Medi-Cal~~the other two (2) lines of business.

2. Capitation Payment Withhold - CalOptima Health shall withhold from each Health Maintenance Organization (HMO), Primary Physician Group, Primary Hospital, and SRG an amount equal to twenty-five percent (25%) of a monthly Capitation Payment, typically computed at the end of each quarter. CalOptima Health may adjust the Capitation Payment each quarter to reflect twenty-five percent (25%) of the current month's Capitation Payment. CalOptima Health may increase this withhold rate based upon its assessment of the operational readiness and financial condition of the HMO, Primary Physician Group, Primary Hospital, or SRG.

3. An HMO contracted on a capitated basis to provide Covered Services to Members shall retain at all times a valid Knox-Keene Act license issued by the California Department of Managed Health Care (DMHC). CalOptima Health shall waive financial security reserves required for an HMO should the HMO meet the statutory requirement and maintain required Tangible Net Equity (TNE) in accordance with Title 28, California Code of Regulations, Section 1300.76.

III. PROCEDURE

A. Health Network Reporting of Financial Information

1. A Health Network shall report financial information to CalOptima Health on a quarterly and annual basis in accordance with CalOptima Health Policy FF.3001: Financial Reporting.

2. A Health Network shall report immediately to CalOptima Health any event that materially alters the Health Network's financial situation or threatens its solvency, pursuant to Title 28, California Code of Regulations; Sections 1300.75.4 through 1300.75.4.8. In such instances, CalOptima Health may require monthly reporting until such time that the Health Network's solvency is no longer in question.

B. CalOptima Health Review of Financial Information

1. CalOptima Health shall review a Health Network's Financial Statements and other financial information on a quarterly and annual basis to evaluate the data, trend indicators for the Health Network, and compare similar indicators between Health Networks including:

   a. Current ratio (must be greater than 1.0);

   b. Cash to claims ratio (must be greater than 0.75);

   c. Tangible Net Equity (TNE) (must be positive);

   d. Operating cash and equivalents position;

   e. Medical claims liability;

   f. Incurred But Not Reported (IBNR) claims;

   g. Debt to equity ratio;

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h. Excess of revenues over expenses;

i. Medical Loss Ratio (MLR); and

j. Administrative cost percentage.

2. CalOptima Health shall ensure that ~~an HMO~~HMOs and ~~a~~ Risk Bearing ~~Organization (RBO) complies~~Organizations (RBOs) comply with the DMHC TNE and fiscal solvency requirements by:

a. Reviewing the HMO's Orange Blank filings;

b. Reviewing ~~the~~each HMO's and RBO's audited Financial Statements and other reports submitted quarterly and annually to DMHC; and

c. Making appropriate inquiries of ~~the~~each HMO's and RBO's key financial personnel during any review.

3. CalOptima Health shall ensure that a contracting Health Network is in compliance with CalOptima Health fiscal solvency requirements by determining if it has established and maintained Financial Solvency Reserves in accordance with the provisions in this policy.

C. CalOptima Health Monitoring of Financial Solvency Reserves

1. Each entity contracted as a Primary Physician Group, Primary Hospital, or SRG shall establish financial security reserves in the form of Financial Security Instruments, as described in Section II.~~B~~C.1.

a. The Financial Security Instruments, in the form of time certificates of deposit, irrevocable standby letters of credit or surety bonds, shall designate CalOptima Health as the sole beneficiary for the duration of the Primary Physician Group, Primary Hospital, or SRG's participation in the CalOptima Health program. CalOptima Health shall access these funds only in the event such funds are needed to protect the interests of and ensure the continuation of Covered Services to Members, or for administrative costs directly attributed to a conservatorship, receivership, or liquidation.

b. The Financial Security Instruments shall require the signature of an authorized CalOptima Health Officer in order to withdraw or transfer funds.

c. CalOptima Health shall monitor the financial security reserves and review their adequacy quarterly.

d. In the event the monthly Capitation Payments to a Primary Physician Group, Primary Hospital, or SRG materially increase due to membership or rate increases, CalOptima Health shall inform the Primary Physician Group, Primary Hospital, or SRG in writing that an increase in financial security reserves is required.

e. CalOptima Health shall not grant an adjustment to the financial security reserves for decreased monthly Capitation Payments to the Primary Physician Group, Primary Hospital, or SRG unless the decrease is material and only upon receiving a formal written request from the Primary Physician Group, Primary Hospital, or SRG.

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f. In the event a Primary Physician Group, Primary Hospital, or SRG requests a substitution of a Financial Security Instrument, they shall submit the new Financial Security Instrument to CalOptima Health. CalOptima Health shall not release the old Financial Security Instrument prior to the receipt of the new Financial Security Instrument.

g. Release of Financial Security Reserves upon Health Network Termination

i. CalOptima Health shall release a Financial Security Instrument no earlier than six (6) months following a Primary Physician Group, Primary Hospital, or SRG's termination in the CalOptima Health program unless the termination is the result of the Primary Physician Group, Primary Hospital, or SRG's insolvency, in which case CalOptima Health shall release a Financial Security Instrument no earlier than twelve (12) months following a Primary Physician Group, Primary Hospital, or SRG's termination in the CalOptima Health program. Release shall only occur after the Primary Physician Group, Primary Hospital, or SRG has met all operational requirements.

ii. CalOptima Health shall inform the Primary Physician Group, Primary Hospital or SRG, in writing, of the expected date CalOptima Health will release a Financial Security Instrument following the Health Network's termination in the CalOptima Health Medi-Cal program.

2. CalOptima Health shall establish a Capitation Payment withhold for a Health Network.

a. CalOptima Health shall monitor Capitation Payment withholds and review their adequacy quarterly as described in Section II.~~B~~C.2.

b. In the event the monthly Capitation Payments to a Health Network materially increase due to membership or rate increases, CalOptima Health shall inform the Health Network in writing that an increase in Capitation withhold is required and shall deduct the additional withhold amount in a future Capitation Payment.

c. In the event the monthly Capitation Payments to a Health Network materially decrease due to membership or rate decreases, CalOptima Health shall release the Capitation Payment withhold surplus to the Health Network in a future Capitation Payment.

d. Release of the Capitation Payment Withhold upon Health Network Termination

i. CalOptima Health shall release a Capitation Payment withhold not earlier than nine (9) months after a Health Network's termination in the CalOptima Health program unless the termination is the result of the Health Network's insolvency, in which case CalOptima Health shall release a Capitation Payment withhold no earlier than twelve (12) months following Health Network's termination in the CalOptima Health program. Release shall only occur after the Health Network has met all operational requirements.

ii. CalOptima Health shall inform the Health Network in writing of the expected date CalOptima Health will release a Capitation Payment withhold following the Health Network's termination in the CalOptima Health program.

D. CalOptima Health Summary and Reporting of Findings

1. CalOptima Health shall prepare summaries of the following:

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a. Financial ratios and other financial elements by Health Network, trended quarterly;

b. Financial security reserves; and

c. Capitation Payment withhold amounts.

2. CalOptima Health shall utilize the summaries described in Section III.D.1 of this Policy to:

a. Monitor the financial position of a Health Network during the Health Network financial review process; and

b. Assess Health Network compliance on an ongoing basis.

3. CalOptima Health shall summarize and report the results of any financial review and Focused Review to the Health Network, the Audit and Oversight Committee, CalOptima Health executive management, and CalOptima Health Finance & Audit Committee (FAC), as needed.

E. Corrective Action and Sanctions

1. If a Health Network fails to comply or meet any of the standards or requirements outlined in this policy, CalOptima Health may take the following actions:

a. Require a Health Network to submit a Corrective Action Plan (CAP) as appropriate, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

b. Place the Health Network in a contractual cure for breach of contract, including the following:

i. CalOptima Health may seize any Capitation and/or monies owed and place the Health Network under financial supervision until breach is cured. Financial supervision to include:

a) Withholding of monthly Capitation; and

b) Managing and releasing withheld Capitation to the Health Network to fund administrative expenses, Primary Care Provider (PCP) Capitation Payments and/or claims payments (limited specifically to months/dates of service that such withheld Capitation was intended to be used for payment);

ii. CalOptima Health may review the Health Network's financial statements, bank statements, and/or other records to ensure payments are made.

2. CalOptima Health may impose Sanctions in accordance with CalOptima Health Policy HH.2002: Sanctions.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal

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B. CalOptima Health Contract with Covered California
~~B.~~C. Contract for Health Care Services
~~C.~~D. CalOptima Health Policy FF.3001: Financial Reporting
~~D.~~E. CalOptima Health Policy HH.2002: Sanctions
~~E.~~F. CalOptima Health Policy HH.2005: Corrective Action Plan
~~F.~~G. Title 10, California Code of Regulations (C.C.R), § 1300.76
~~G.~~H. ~~Title~~ 22~~, California Code of Regulations (~~ C.C.R~~),~~ § 51301 *et seq.*
~~H.~~I. ~~Title~~ 28~~, California Code of Regulations (~~ C.C.R~~),~~ §§ 1300.75.4 through 1300.75.4.8

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/07/2016	Department of Health Care Services (DHCS)	Approved as Submitted
06/26/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/04/2020	Regular Meeting of the CalOptima Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.3002	Financial Oversight	Medi-Cal
Revised	01/01/2008	FF.3002	Financial Oversight	Medi-Cal
Revised	02/01/2016	FF.3002	Financial Oversight	Medi-Cal
Revised	03/01/2017	FF.3002	Financial Oversight	Medi-Cal
Revised	07/01/2018	FF.3002	Financial Oversight	Medi-Cal
Revised	06/04/2020	FF.3002	Financial Oversight	Medi-Cal
Revised	08/01/2021	FF.3002	Financial Oversight	Medi-Cal
Revised	05/01/2022	FF.3002	Financial Oversight	Medi-Cal
Revised	07/01/2023	FF.3002	Financial Oversight	Medi-Cal
Revised	08/01/2024	FF.3002	Financial Oversight	Medi-Cal
Revised	07/01/2025	FF.3002	Financial Oversight	Covered California Medi-Cal

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IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.
Capitation Payment	The monthly amount paid to a Health Network by CalOptima Health for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
Capitation Rate	The per capita rate set by CalOptima Health for the delivery of Covered Services to Members based upon Aid Code, age and gender.
Contract for Health Care Services	The written instrument between CalOptima Health and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima Health that is binding on a Physician Hospital Consortium (PHC), a physician group under a shared risk contract, or HMO, and DHCS Medi-Cal Managed Care Division Policy Letters. .
Corrective Action Plan (CAP)	Covered California: A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), DHCS, Covered California, DMHC, or designated representatives. First tier, downstream, or related entities (FDRs) and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators, in accordance with HH.2005: Corrective Action Plan. Medi-Cal: A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Covered Services	Covered California: Health care services that are covered benefits under CalOptima Health's contract with Covered California as further described in the Evidence of Coverage and supporting documents. Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include:

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Term	Definition
	1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services;

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Term	Definition
	13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012.
Department of Managed Health Care (DMHC)	The State Agency responsible for licensing and regulating health care services plans/health maintenance organizations in accordance with the Knox Keene Health Care Service Plan Act of 1975 as amended.
Financial Solvency Reserves	Funds comprised of security reserves and/or capitation withhold that are required for the duration of a Physician Hospital Consortium's (PHC)'s, Shared Risk Group's (SRG)'s, or Health Maintenance Organization's (HMO) participation in the CalOptima Health program. These funds are used to protect the interests of and ensure the continuation of health care services to the Members assigned to the PHC, SRG or HMO; they may also be used for administrative costs directly attributable to a conservatorship, receivership or liquidation.
Financial Statement	For purposes of this policy, reports prepared by an entity such as a Health Network to present its financial performance and position at a point in time, and include a balance sheet, income statement, statement of cash flows, statement of equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles (GAAP).
Financial Security Instrument	Time certificate of deposit, irrevocable standby letter of credit, or surety bond naming CalOptima Health as the beneficiary.
Focused Review	An audit that specifically targets areas of potential deficiency.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene ~~Health Care Service Plan Act of 1975, as amended,~~Act,, commencing with Section 1340 of the California Health and Safety Code.
Health Network	For the purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network, either directly or through the use of subcontractors and downstream subcontractors that may be subject to the terms of this policy~~.~~

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Term	Definition
Incurred But Not Reported (IBNR)	Covered California: Refers to an unpaid claim liability or claim reserve established by the health plan or the Health Network for healthcare services that have been rendered by the provider but not yet paid by the plan. This is also referred to as Incurred But Not Paid (IBNP). Medi-Cal: An estimate of claims that have been incurred for medical services provided, but for which claims have not yet been received by the Health Network.
Knox-Keene Health Care Services Plan Act of 1975 (Knox-Keene Act)	The law that regulates HMOs and is administrated by the Department of Managed Health Care (DMHC), commencing with Section 1340 of the California Health and Safety Code.
Medical Loss Ratio (MLR)	The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Health Members by the total revenue received from CalOptima Health. Health Network medical costs would include payments to physicians (i.e. capitation, fee-for-service, or salary), medical groups/ independent practice Associations (IPAs), hospitals, labs, ambulance companies, and other providers of service.
Member	~~A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS)~~ An individual enrolled in a CalOptima Health program. ~~Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.~~
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Primary Hospital	A hospital contracted with CalOptima Health on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC).
Primary Physician Group	A physician group contracted with CalOptima Health on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC).
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services. Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Risk Bearing Organization (RBO)	A professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, or another lawfully organized group of physicians that: 1. Delivers, furnishes, or otherwise arranges for or provides health care services; and 2. Does all the following: a. Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees; b. Receives compensation for those services on a capitated or fixed periodic payment basis; and

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Term	Definition
	c. Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation payment made by the plan to the risk bearing organization.
Sanction	Action taken by CalOptima Health including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, CalOptima Health policy, or other requirements related to CalOptima Health programs.
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima Health as the responsible partner for facility services.
Tangible Net Equity (TNE)	Net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates and which are not past due; long term prepayments of deferred charges, and non-returnable deposits.

1

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Policy:	FF.3002
Title:	**Financial Oversight**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	07/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy outlines the process by which CalOptima monitors a Health Network's financial position and financial security reserves to ensure contract compliance and financial integrity.

II. POLICY

A. The requirements set forth in this policy apply to Medi-Cal and Covered California.

B. CalOptima Health shall conduct Health Network financial reviews and periodic Focused Reviews as it deems necessary. CalOptima Health shall monitor a Health Network's financial position to promote:

1. Access to quality care for Members enrolled in the Health Network;

2. Appropriate and timely payment to Providers that render Covered Services to Members enrolled in the Health Network;

3. Financial integrity of CalOptima Health and its contractors; and

4. Financially prudent utilization of Capitation revenues received from the State of California.

C. Pursuant to the Contract for Health Care Services, CalOptima Health shall ensure that a Health Network complies with Financial Solvency Reserve requirements.

1. Financial Security Reserves - Each entity contracted as a Primary Physician Group, Primary Hospital, or Shared Risk Group (SRG) shall establish and maintain financial security reserves in the form of time certificates of deposit, irrevocable standby letters of credit, or surety bonds naming CalOptima Health as beneficiary, equal to fifty thousand dollars ($50,000) plus a minimum of twenty-five percent (25%) of one (1) month's average Capitation Payment, typically computed at the end of each quarter. CalOptima Health may require a greater amount based upon its assessment of the operational readiness and financial condition of the Primary Physician Group, Primary Hospital, or SRG. If the entity meets the fifty thousand dollars ($50,000) element of the financial security reserve requirement for participation as a contract

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holder with CalOptima Health for Medi-Cal, OneCare, or Covered California Members, the entity shall be deemed to have met the fifty thousand dollars ($50,000) element of the financial security reserve requirement for the other two (2) lines of business.

2. Capitation Payment Withhold - CalOptima Health shall withhold from each Health Maintenance Organization (HMO), Primary Physician Group, Primary Hospital, and SRG an amount equal to twenty-five percent (25%) of a monthly Capitation Payment, typically computed at the end of each quarter. CalOptima Health may adjust the Capitation Payment each quarter to reflect twenty-five percent (25%) of the current month's Capitation Payment. CalOptima Health may increase this withhold rate based upon its assessment of the operational readiness and financial condition of the HMO, Primary Physician Group, Primary Hospital, or SRG.

3. An HMO contracted on a capitated basis to provide Covered Services to Members shall retain at all times a valid Knox-Keene Act license issued by the California Department of Managed Health Care (DMHC). CalOptima Health shall waive financial security reserves required for an HMO should the HMO meet the statutory requirement and maintain required Tangible Net Equity (TNE) in accordance with Title 28, California Code of Regulations, Section 1300.76.

III. PROCEDURE

A. Health Network Reporting of Financial Information

1. A Health Network shall report financial information to CalOptima Health on a quarterly and annual basis in accordance with CalOptima Health Policy FF.3001: Financial Reporting.

2. A Health Network shall report immediately to CalOptima Health any event that materially alters the Health Network's financial situation or threatens its solvency, pursuant to Title 28, California Code of Regulations; Sections 1300.75.4 through 1300.75.4.8. In such instances, CalOptima Health may require monthly reporting until such time that the Health Network's solvency is no longer in question.

B. CalOptima Health Review of Financial Information

1. CalOptima Health shall review a Health Network's Financial Statements and other financial information on a quarterly and annual basis to evaluate the data, trend indicators for the Health Network, and compare similar indicators between Health Networks including:

a. Current ratio (must be greater than 1.0);

b. Cash to claims ratio (must be greater than 0.75);

c. Tangible Net Equity (TNE) (must be positive);

d. Operating cash and equivalents position;

e. Medical claims liability;

f. Incurred But Not Reported (IBNR) claims;

g. Debt to equity ratio;

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h. Excess of revenues over expenses;

i. Medical Loss Ratio (MLR); and

j. Administrative cost percentage.

2. CalOptima Health shall ensure that HMOs and Risk Bearing Organizations (RBOs) comply with the DMHC TNE and fiscal solvency requirements by:

a. Reviewing the HMO's Orange Blank filings;

b. Reviewing each HMO's and RBO's audited Financial Statements and other reports submitted quarterly and annually to DMHC; and

c. Making appropriate inquiries of each HMO's and RBO's key financial personnel during any review.

3. CalOptima Health shall ensure that a contracting Health Network is in compliance with CalOptima Health fiscal solvency requirements by determining if it has established and maintained Financial Solvency Reserves in accordance with the provisions in this policy.

C. CalOptima Health Monitoring of Financial Solvency Reserves

1. Each entity contracted as a Primary Physician Group, Primary Hospital, or SRG shall establish financial security reserves in the form of Financial Security Instruments, as described in Section II.C.1.

a. The Financial Security Instruments, in the form of time certificates of deposit, irrevocable standby letters of credit or surety bonds, shall designate CalOptima Health as the sole beneficiary for the duration of the Primary Physician Group, Primary Hospital, or SRG's participation in the CalOptima Health program. CalOptima Health shall access these funds only in the event such funds are needed to protect the interests of and ensure the continuation of Covered Services to Members, or for administrative costs directly attributed to a conservatorship, receivership, or liquidation.

b. The Financial Security Instruments shall require the signature of an authorized CalOptima Health Officer in order to withdraw or transfer funds.

c. CalOptima Health shall monitor the financial security reserves and review their adequacy quarterly.

d. In the event the monthly Capitation Payments to a Primary Physician Group, Primary Hospital, or SRG materially increase due to membership or rate increases, CalOptima Health shall inform the Primary Physician Group, Primary Hospital, or SRG in writing that an increase in financial security reserves is required.

e. CalOptima Health shall not grant an adjustment to the financial security reserves for decreased monthly Capitation Payments to the Primary Physician Group, Primary Hospital, or SRG unless the decrease is material and only upon receiving a formal written request from the Primary Physician Group, Primary Hospital, or SRG.

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f. In the event a Primary Physician Group, Primary Hospital, or SRG requests a substitution of a Financial Security Instrument, they shall submit the new Financial Security Instrument to CalOptima Health. CalOptima Health shall not release the old Financial Security Instrument prior to the receipt of the new Financial Security Instrument.

g. Release of Financial Security Reserves upon Health Network Termination

i. CalOptima Health shall release a Financial Security Instrument no earlier than six (6) months following a Primary Physician Group, Primary Hospital, or SRG's termination in the CalOptima Health program unless the termination is the result of the Primary Physician Group, Primary Hospital, or SRG's insolvency, in which case CalOptima Health shall release a Financial Security Instrument no earlier than twelve (12) months following a Primary Physician Group, Primary Hospital, or SRG's termination in the CalOptima Health program. Release shall only occur after the Primary Physician Group, Primary Hospital, or SRG has met all operational requirements.

ii. CalOptima Health shall inform the Primary Physician Group, Primary Hospital or SRG, in writing, of the expected date CalOptima Health will release a Financial Security Instrument following the Health Network's termination in the CalOptima Health Medi-Cal program.

2. CalOptima Health shall establish a Capitation Payment withhold for a Health Network.

a. CalOptima Health shall monitor Capitation Payment withholds and review their adequacy quarterly as described in Section II.C.2.

b. In the event the monthly Capitation Payments to a Health Network materially increase due to membership or rate increases, CalOptima Health shall inform the Health Network in writing that an increase in Capitation withhold is required and shall deduct the additional withhold amount in a future Capitation Payment.

c. In the event the monthly Capitation Payments to a Health Network materially decrease due to membership or rate decreases, CalOptima Health shall release the Capitation Payment withhold surplus to the Health Network in a future Capitation Payment.

d. Release of the Capitation Payment Withhold upon Health Network Termination

i. CalOptima Health shall release a Capitation Payment withhold not earlier than nine (9) months after a Health Network's termination in the CalOptima Health program unless the termination is the result of the Health Network's insolvency, in which case CalOptima Health shall release a Capitation Payment withhold no earlier than twelve (12) months following Health Network's termination in the CalOptima Health program. Release shall only occur after the Health Network has met all operational requirements.

ii. CalOptima Health shall inform the Health Network in writing of the expected date CalOptima Health will release a Capitation Payment withhold following the Health Network's termination in the CalOptima Health program.

D. CalOptima Health Summary and Reporting of Findings

1. CalOptima Health shall prepare summaries of the following:

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a. Financial ratios and other financial elements by Health Network, trended quarterly;

b. Financial security reserves; and

c. Capitation Payment withhold amounts.

2. CalOptima Health shall utilize the summaries described in Section III.D.1 of this Policy to:

a. Monitor the financial position of a Health Network during the Health Network financial review process; and

b. Assess Health Network compliance on an ongoing basis.

3. CalOptima Health shall summarize and report the results of any financial review and Focused Review to the Health Network, the Audit and Oversight Committee, CalOptima Health executive management, and CalOptima Health Finance & Audit Committee (FAC), as needed.

E. Corrective Action and Sanctions

1. If a Health Network fails to comply or meet any of the standards or requirements outlined in this policy, CalOptima Health may take the following actions:

a. Require a Health Network to submit a Corrective Action Plan (CAP) as appropriate, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

b. Place the Health Network in a contractual cure for breach of contract, including the following:

i. CalOptima Health may seize any Capitation and/or monies owed and place the Health Network under financial supervision until breach is cured. Financial supervision to include:

a) Withholding of monthly Capitation; and

b) Managing and releasing withheld Capitation to the Health Network to fund administrative expenses, Primary Care Provider (PCP) Capitation Payments and/or claims payments (limited specifically to months/dates of service that such withheld Capitation was intended to be used for payment);

ii. CalOptima Health may review the Health Network's financial statements, bank statements, and/or other records to ensure payments are made.

2. CalOptima Health may impose Sanctions in accordance with CalOptima Health Policy HH.2002: Sanctions.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal

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B. CalOptima Health Contract with Covered California
C. Contract for Health Care Services
D. CalOptima Health Policy FF.3001: Financial Reporting
E. CalOptima Health Policy HH.2002: Sanctions
F. CalOptima Health Policy HH.2005: Corrective Action Plan
G. Title 10, California Code of Regulations (C.C.R), § 1300.76
H. 22 C.C.R § 51301 *et seq.*
I. 28 C.C.R §§ 1300.75.4 through 1300.75.4.8

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/07/2016	Department of Health Care Services (DHCS)	Approved as Submitted
06/26/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/04/2020	Regular Meeting of the CalOptima Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	FF.3002	Financial Oversight	Medi-Cal
Revised	01/01/2008	FF.3002	Financial Oversight	Medi-Cal
Revised	02/01/2016	FF.3002	Financial Oversight	Medi-Cal
Revised	03/01/2017	FF.3002	Financial Oversight	Medi-Cal
Revised	07/01/2018	FF.3002	Financial Oversight	Medi-Cal
Revised	06/04/2020	FF.3002	Financial Oversight	Medi-Cal
Revised	08/01/2021	FF.3002	Financial Oversight	Medi-Cal
Revised	05/01/2022	FF.3002	Financial Oversight	Medi-Cal
Revised	07/01/2023	FF.3002	Financial Oversight	Medi-Cal
Revised	08/01/2024	FF.3002	Financial Oversight	Medi-Cal
Revised	07/01/2025	FF.3002	Financial Oversight	Covered California Medi-Cal

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IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.
Capitation Payment	The monthly amount paid to a Health Network by CalOptima Health for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender.
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	13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012.
Department of Managed Health Care (DMHC)	The State Agency responsible for licensing and regulating health care services plans/health maintenance organizations in accordance with the Knox Keene Health Care Service Plan Act of 1975 as amended.
Financial Solvency Reserves	Funds comprised of security reserves and/or capitation withhold that are required for the duration of a Physician Hospital Consortium's (PHC)'s, Shared Risk Group's (SRG)'s, or Health Maintenance Organization's (HMO) participation in the CalOptima Health program. These funds are used to protect the interests of and ensure the continuation of health care services to the Members assigned to the PHC, SRG or HMO; they may also be used for administrative costs directly attributable to a conservatorship, receivership or liquidation.
Financial Statement	For purposes of this policy, reports prepared by an entity such as a Health Network to present its financial performance and position at a point in time, and include a balance sheet, income statement, statement of cash flows, statement of equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles (GAAP).
Financial Security Instrument	Time certificate of deposit, irrevocable standby letter of credit, or surety bond naming CalOptima Health as the beneficiary.
Focused Review	An audit that specifically targets areas of potential deficiency.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Act,, commencing with Section 1340 of the California Health and Safety Code.
Health Network	For the purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network, either directly or through the use of subcontractors and downstream subcontractors that may be subject to the terms of this policy

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Term	Definition
Incurred But Not Reported (IBNR)	Covered California: Refers to an unpaid claim liability or claim reserve established by the health plan or the Health Network for healthcare services that have been rendered by the provider but not yet paid by the plan. This is also referred to as Incurred But Not Paid (IBNP). Medi-Cal: An estimate of claims that have been incurred for medical services provided, but for which claims have not yet been received by the Health Network.
Knox-Keene Health Care Services Plan Act of 1975 (Knox-Keene Act)	The law that regulates HMOs and is administrated by the Department of Managed Health Care (DMHC), commencing with Section 1340 of the California Health and Safety Code.
Medical Loss Ratio (MLR)	The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Health Members by the total revenue received from CalOptima Health. Health Network medical costs would include payments to physicians (i.e. capitation, fee-for-service, or salary), medical groups/ independent practice Associations (IPAs), hospitals, labs, ambulance companies, and other providers of service.
Member	An individual enrolled in a CalOptima Health program.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Primary Hospital	A hospital contracted with CalOptima Health on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC).
Primary Physician Group	A physician group contracted with CalOptima Health on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC).
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services. Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Risk Bearing Organization (RBO)	A professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, or another lawfully organized group of physicians that: 1. Delivers, furnishes, or otherwise arranges for or provides health care services; and 2. Does all the following: a. Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees; b. Receives compensation for those services on a capitated or fixed periodic payment basis; and c. Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation payment made by the plan to the risk bearing organization.

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Term	Definition
Sanction	Action taken by CalOptima Health including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, CalOptima Health policy, or other requirements related to CalOptima Health programs.
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima Health as the responsible partner for facility services.
Tangible Net Equity (TNE)	Net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates and which are not past due; long term prepayments of deferred charges, and non-returnable deposits.

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For 20250904 BOD Review Only

Policy:	FF.3003
Title:	**Minimum Medical Loss Ratio**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2003
Revised Date:	07/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☐ PACE

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I. PURPOSE

This policy defines the minimum acceptable Health Network Medical Loss Ratio (MLR) included as part of a Health Network's participation requirement and if applicable, as required by ~~the~~ Department of Health Care Services (DHCS) for a Medi-Cal Managed Care Plan's Subcontractors and Downstream Subcontractors.

II. POLICY

A. A Health Network shall maintain a minimum MLR, as defined herein, throughout the term of its Health Network Contract.

1. A Health Network shall be required to submit evidence of maintenance of the minimum MLR as described in Section III.F. of this policy, regardless of DHCS reporting requirements.

B. A Health Network that fails to comply with the minimum MLR as described in this policy may be subject to penalties and Sanctions, up to and including termination, pursuant to its Health Network Contract, and CalOptima Health Policy HH.2002: Sanctions.

C. A Health Network must ensure that its Subcontractor(s) and Downstream Subcontractor(s) subject to DHCS MLR requirements comply with CalOptima Health policies regarding MLR, including this policy, and DHCS policy letters.

III. PROCEDURE

A. Throughout the term of its Health Network Contract, a Health Network shall maintain a minimum MLR of no less than eighty-five percent (85%) in each calendar year (CY). CalOptima Health shall measure a Health Network's MLR performance for each CY.

B. Effective CY 2023, Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors, subject to the DHCS imposed materiality threshold, are required to comply with equivalent MLR reporting responsibilities.

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C. Effective CY 2025, Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors, subject to the DHCS imposed materiality threshold, are required to comply with equivalent MLR remittance responsibilities.

D. CalOptima Health, and DHCS as applicable, reserves the right to measure a Health Network's MLR using a different measurement period other than a calendar year.

E. The minimum MLR shall apply to the Health Network's contracts for CalOptima Health Medi-Cal ~~and~~, OneCare, and Covered California Members, on an individual basis.

F. A Health Network shall utilize the most current ~~DHCS Special Terms and Conditions (STC) Annual Medi-Cal~~ MLR Reporting Template for Medi-Cal ~~and Annual Financial Reporting Form (AFRF) for~~, OneCare, and Covered California provided by CalOptima Health, to report its MLR within one hundred fifty (150) calendar days after the close of each CY, in accordance with CalOptima Health Policy FF.3001: Financial Reporting. For Medi-Cal, a Health Maintenance Organization (HMO) shall report its MLR on a consolidated physician and hospital basis. For OneCare, a Physician Hospital Consortium (PHC) and HMO shall report its MLR on a consolidated physician and hospital basis.

G. A Health Network shall prepare its financial documentation in accordance with generally accepted accounting principles (GAAP) and on an accrual basis of accounting.

H. A Health Network shall cooperate with CalOptima Health or its contracted vendor to complete a review of documentation supporting its MLR following submission of the final MLR reports for the CY.

I. Medi-Cal Requirements Based on DHCS MLR Requirements

1. Materiality threshold for MLR reporting and remittance. Health Networks that meet a materiality threshold, as established by DHCS, must comply with DHCS MLR reporting and remittance requirements. Health Networks that do not meet the DHCS-established materiality threshold may be required to submit an MLR report at DHCS' discretion.

2. MLR reporting and remittance exemption. CalOptima may exempt a newly contracted Health Network from the DHCS MLR reporting requirements in the first year of the Health Network's operation under its contract with CalOptima Health CalOptima will report any MLR reporting exemption that it grants to DHCS. If DHCS or CalOptima Health reverses an MLR reporting exemption, the Health Network must comply with all applicable MLR reporting and remittance requirements.

3. MLR reporting. The MLR report must comply with applicable DHCS requirements and be submitted to CalOptima Health as outlined in CalOptima Health Policy FF.3001: Financial Reporting.

4. MLR reporting oversight. Health Network shall comply with CalOptima Health's oversight and monitoring activities related to the Health Network's MLR, that could include but are not limited to:

   a. Review of each Health Network's MLR and reported medical cost per Member per month to identify and investigate outliers;

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b. Review of reported expenses to ensure medical and non-medical expenses are appropriately accounted for in the MLR calculation;

c. Verification that reported expenses align with service volume reported in encounters;

d. Verification that reported revenues align with the upstream entities' reported payments;

e. Review of the reasonableness of methodologies for allocation of expenditures across multiple lines of business; and

f. Review of the reasonableness of incurred but not reported (IBNR) estimates.

g. Physician Distribution payments must be tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers.

h. Allocation methodologies must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, federal and state taxes and licensing or regulatory fees, and other non-claims costs.

5. Retroactive MLR reporting: If DHCS makes retroactive changes to CalOptima Health's capitation payments for an MLR measurement period and the Health Network has already submitted its MLR report to CalOptima, the Health Network must re-calculate the MLR for all MLR measurement periods affected by the change and submit a new MLR report to CalOptima Health. Health Networks must comply with any requirements and limitations on re-reporting and ad-hoc MLR reporting, as may be determined by DHCS. Health Network will not be required to re-report its MLR to CalOptima Health more than once for any MLR measurement period without DHCS approval.

6. Remittance: Effective CY 2025, if the Health Network's MLR reported to CalOptima Health for an MLR measurement period falls below the minimum requirement of eighty-five percent (85%), the Health Network must provide a remittance to CalOptima Health. CalOptima Health will validate the Health Network's reported remittance amount owed to CalOptima Health for each MLR measurement period.

7. Subcontractor compliance: Health Network must impose the DHCS MLR requirements detailed in this policy on its Subcontractors and Downstream Subcontractors that meet DHCS materiality thresholds and accept financial risk to perform activities or reporting responsibilities delegated to Health Network by CalOptima. At minimum, Health Network must ensure that its Subcontractors and Downstream Subcontractors:

a. Maintain a minimum MLR level of eighty-five percent (85%);

b. Submit MLR reports upstream to Health Network in compliance with this policy and DHCS requirements;

c. Comply with Health Network's MLR oversight and monitoring activities;

d. Submit remittances to Health Network; and

e. Comply with retroactive MLR reporting, as applicable.

IV. ATTACHMENTS

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Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Contract with Covered California
~~B.~~C. CalOptima Health Policy FF.3001: Financial Reporting
~~C.~~D. CalOptima Health Policy HH.2002: Sanctions
~~D.~~E. Health Network Contract
~~E.~~F. Title 42, Code of Federal Regulations (CFR), Section 438.8

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/03/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/26/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
05/07/2002	Regular Meeting of the CalOptima Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2003	FF.3003	Minimum Medical Loss Ratio	Medi-Cal
Revised	05/22/2003	FF.3003	Minimum Medical Loss Ratio	Medi-Cal
Revised	01/01/2004	FF.3003	Minimum Medical Loss Ratio	Medi-Cal
Revised	01/01/2007	FF.3003	Minimum Medical Loss Ratio	Medi-Cal
Revised	09/01/2014	FF.3003	Minimum Medical Loss Ratio	Medi-Cal
Revised	07/01/2016	FF.3003	Minimum Medical Loss Ratio	Medi-Cal OneCare Connect
Revised	12/01/2017	FF.3003	Minimum Medical Loss Ratio	Medi-Cal OneCare Connect
Revised	12/01/2018	FF.3003	Minimum Medical Loss Ratio	Medi-Cal OneCare Connect
Revised	10/01/2019	FF.3003	Minimum Medical Loss Ratio	Medi-Cal OneCare Connect
Revised	06/01/2020	FF.3003	Minimum Medical Loss Ratio	Medi-Cal OneCare Connect
Revised	09/01/2023	FF.3003	Minimum Medical Loss Ratio	Medi-Cal OneCare
Revised	12/01/2024	FF.3003	Minimum Medical Loss Ratio	Medi-Cal OneCare

For Board Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	07/01/2025	FF.3003	Minimum Medical Loss Ratio	Covered California Medi-Cal OneCare

For 20250904 BOD Review Only

IX. GLOSSARY

Term	Definition
Downstream Subcontractor	An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
Downstream Subcontractor Agreement	For purposes of this policy, a written agreement between a Subcontractor and a Downstream Subcontractor or between any Downstream Subcontractors. The Downstream Subcontractor Agreement must include a delegation of CalOptima Health's and Subcontractor's duties and obligations.
Fully Delegated Subcontractor	A Subcontractor that contractually assumes all duties and obligations of CalOptima Health under the Contract, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Fully Delegated Subcontractor.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended commencing with Section 1340 of the California Health and Safety Code.
Health Network	For the purposes of this policy, a ~~physician group under a~~ Physician Hospital Consortium (PHC~~) contract, a hospital under a PHC contract,~~), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network, either directly or through the use of subcontractors and downstream subcontractors that may be subject to the terms of this policy~~.~~
Health Network Contract	For purposes of this policy, the applicable written instrument between CalOptima and a Health Network, for the purposes of providing delegated services to assigned Members. Health Network Contracts include the Contract for Health Care Services and the Medicare Advantage Service Agreement, including any and all amendments thereto.
Medical Loss Ratio (MLR)	The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Health Members by the total revenue received from CalOptima Health. Health Network medical costs would include incurred claims, expenditures for activities that improve healthcare quality, and fraud reduction activities.
Member	A beneficiary enrolled in a CalOptima Health program.
Network Provider	Covered California: Any Provider or entity that CalOptima Health has contracted with to deliver Covered Services for a specific network service area as defined in 28 CCR 1300.67.2.2(b)(10). Medi-Cal: Any Provider or entity that has a Network Provider Agreement with CalOptima Health or CalOptima Health's Subcontractor(s) and receives Medi-Cal funding directly or indirectly to order refer or render Covered Services under the contract between said parties. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.

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Term	Definition
Network Provider Agreement	A written agreement between a Network Provider and contractor, Subcontractor, or Downstream Subcontractor.
Partially Delegated Subcontractor	A Subcontractor that contractually assumes some, but not all, duties and obligations of CalOptima Health under the Contract, including, for example, obligations regarding specific Member populations or obligations regarding a specific set of services. Individual physician associations and medical groups often operate as Partially Delegated Subcontractors.
Physician Hospital Consortium (PHC)	A physician group or physician groups contractually aligned with at least one (1) hospital to provide Medi-Cal services to a common set of assigned Members, as described in CalOptima Health's Contract for Health Care Services.
Sanction	Action taken by CalOptima Health including, without limitations, restrictions, monetary fines, termination or a combination thereof, based on a Health Network's or its delegate's, subcontractor's, or any Health Network partner's failure to comply with statutory, regulatory, contractual, CalOptima Health policy, or other requirements related to the CalOptima Health Medi-Cal program.
Subcontractor	An individual or entity that has a Subcontractor Agreement with contractor that relates directly or indirectly to the performance of contractor's obligations under this contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.
Subcontractor Agreement	For the purposes of this policy, a written agreement between CalOptima Health or CalOptima Health's Subcontractor and a Subcontractor. The Subcontractor Agreement must include a delegation of CalOptima Health's duties and obligations.

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Policy:	FF.3003
Title:	**Minimum Medical Loss Ratio**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2003
Revised Date:	07/01/2025
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☐ PACE

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I. PURPOSE

This policy defines the minimum acceptable Health Network Medical Loss Ratio (MLR) included as part of a Health Network's participation requirement and if applicable, as required by Department of Health Care Services (DHCS) for a Medi-Cal Managed Care Plan's Subcontractors and Downstream Subcontractors.

II. POLICY

A. A Health Network shall maintain a minimum MLR, as defined herein, throughout the term of its Health Network Contract.

1. A Health Network shall be required to submit evidence of maintenance of the minimum MLR as described in Section III.F. of this policy, regardless of DHCS reporting requirements.

B. A Health Network that fails to comply with the minimum MLR as described in this policy may be subject to penalties and Sanctions, up to and including termination, pursuant to its Health Network Contract, and CalOptima Health Policy HH.2002: Sanctions.

C. A Health Network must ensure that its Subcontractor(s) and Downstream Subcontractor(s) subject to DHCS MLR requirements comply with CalOptima Health policies regarding MLR, including this policy, and DHCS policy letters.

III. PROCEDURE

A. Throughout the term of its Health Network Contract, a Health Network shall maintain a minimum MLR of no less than eighty-five percent (85%) in each calendar year (CY). CalOptima Health shall measure a Health Network's MLR performance for each CY.

B. Effective CY 2023, Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors, subject to the DHCS imposed materiality threshold, are required to comply with equivalent MLR reporting responsibilities.

C. Effective CY 2025, Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors, subject to the DHCS imposed materiality threshold, are required to comply with equivalent MLR remittance responsibilities.

D. CalOptima Health, and DHCS as applicable, reserves the right to measure a Health Network's MLR using a different measurement period other than a calendar year.

E. The minimum MLR shall apply to the Health Network's contracts for CalOptima Health Medi-Cal, OneCare, and Covered California Members, on an individual basis.

F. A Health Network shall utilize the most current MLR Reporting Template for Medi-Cal, OneCare, and Covered California provided by CalOptima Health, to report its MLR within one hundred fifty (150) calendar days after the close of each CY, in accordance with CalOptima Health Policy FF.3001: Financial Reporting. For Medi-Cal, a Health Maintenance Organization (HMO) shall report its MLR on a consolidated physician and hospital basis. For OneCare, a Physician Hospital Consortium (PHC) and HMO shall report its MLR on a consolidated physician and hospital basis.

G. A Health Network shall prepare its financial documentation in accordance with generally accepted accounting principles (GAAP) and on an accrual basis of accounting.

H. A Health Network shall cooperate with CalOptima Health or its contracted vendor to complete a review of documentation supporting its MLR following submission of the final MLR reports for the CY.

I. Medi-Cal Requirements Based on DHCS MLR Requirements

1. Materiality threshold for MLR reporting and remittance. Health Networks that meet a materiality threshold, as established by DHCS, must comply with DHCS MLR reporting and remittance requirements. Health Networks that do not meet the DHCS-established materiality threshold may be required to submit an MLR report at DHCS' discretion.

2. MLR reporting and remittance exemption. CalOptima may exempt a newly contracted Health Network from the DHCS MLR reporting requirements in the first year of the Health Network's operation under its contract with CalOptima Health CalOptima will report any MLR reporting exemption that it grants to DHCS. If DHCS or CalOptima Health reverses an MLR reporting exemption, the Health Network must comply with all applicable MLR reporting and remittance requirements.

3. MLR reporting. The MLR report must comply with applicable DHCS requirements and be submitted to CalOptima Health as outlined in CalOptima Health Policy FF.3001: Financial Reporting.

4. MLR reporting oversight. Health Network shall comply with CalOptima Health's oversight and monitoring activities related to the Health Network's MLR, that could include but are not limited to:

   a. Review of each Health Network's MLR and reported medical cost per Member per month to identify and investigate outliers;

   b. Review of reported expenses to ensure medical and non-medical expenses are appropriately accounted for in the MLR calculation;

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c. Verification that reported expenses align with service volume reported in encounters;

d. Verification that reported revenues align with the upstream entities' reported payments;

e. Review of the reasonableness of methodologies for allocation of expenditures across multiple lines of business; and

f. Review of the reasonableness of incurred but not reported (IBNR) estimates.

g. Physician Distribution payments must be tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers.

h. Allocation methodologies must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, federal and state taxes and licensing or regulatory fees, and other non-claims costs.

5. Retroactive MLR reporting: If DHCS makes retroactive changes to CalOptima Health's capitation payments for an MLR measurement period and the Health Network has already submitted its MLR report to CalOptima, the Health Network must re-calculate the MLR for all MLR measurement periods affected by the change and submit a new MLR report to CalOptima Health. Health Networks must comply with any requirements and limitations on re-reporting and ad-hoc MLR reporting, as may be determined by DHCS. Health Network will not be required to re-report its MLR to CalOptima Health more than once for any MLR measurement period without DHCS approval.

6. Remittance: Effective CY 2025, if the Health Network's MLR reported to CalOptima Health for an MLR measurement period falls below the minimum requirement of eighty-five percent (85%), the Health Network must provide a remittance to CalOptima Health. CalOptima Health will validate the Health Network's reported remittance amount owed to CalOptima Health for each MLR measurement period.

7. Subcontractor compliance: Health Network must impose the DHCS MLR requirements detailed in this policy on its Subcontractors and Downstream Subcontractors that meet DHCS materiality thresholds and accept financial risk to perform activities or reporting responsibilities delegated to Health Network by CalOptima. At minimum, Health Network must ensure that its Subcontractors and Downstream Subcontractors:

a. Maintain a minimum MLR level of eighty-five percent (85%);

b. Submit MLR reports upstream to Health Network in compliance with this policy and DHCS requirements;

c. Comply with Health Network's MLR oversight and monitoring activities;

d. Submit remittances to Health Network; and

e. Comply with retroactive MLR reporting, as applicable.

IV. ATTACHMENTS

Not Applicable

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V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Contract with Covered California
C. CalOptima Health Policy FF.3001: Financial Reporting
D. CalOptima Health Policy HH.2002: Sanctions
E. Health Network Contract
F. Title 42, Code of Federal Regulations (CFR), Section 438.8

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/03/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/26/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
05/07/2002	Regular Meeting of the CalOptima Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2003	FF.3003	Minimum Medical Loss Ratio	Medi-Cal
Revised	05/22/2003	FF.3003	Minimum Medical Loss Ratio	Medi-Cal
Revised	01/01/2004	FF.3003	Minimum Medical Loss Ratio	Medi-Cal
Revised	01/01/2007	FF.3003	Minimum Medical Loss Ratio	Medi-Cal
Revised	09/01/2014	FF.3003	Minimum Medical Loss Ratio	Medi-Cal
Revised	07/01/2016	FF.3003	Minimum Medical Loss Ratio	Medi-Cal OneCare Connect
Revised	12/01/2017	FF.3003	Minimum Medical Loss Ratio	Medi-Cal OneCare Connect
Revised	12/01/2018	FF.3003	Minimum Medical Loss Ratio	Medi-Cal OneCare Connect
Revised	10/01/2019	FF.3003	Minimum Medical Loss Ratio	Medi-Cal OneCare Connect
Revised	06/01/2020	FF.3003	Minimum Medical Loss Ratio	Medi-Cal OneCare Connect
Revised	09/01/2023	FF.3003	Minimum Medical Loss Ratio	Medi-Cal OneCare
Revised	12/01/2024	FF.3003	Minimum Medical Loss Ratio	Medi-Cal OneCare
Revised	07/01/2025	FF.3003	Minimum Medical Loss Ratio	Covered California Medi-Cal OneCare

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IX. GLOSSARY

Term	Definition
Downstream Subcontractor	An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
Downstream Subcontractor Agreement	For purposes of this policy, a written agreement between a Subcontractor and a Downstream Subcontractor or between any Downstream Subcontractors. The Downstream Subcontractor Agreement must include a delegation of CalOptima Health's and Subcontractor's duties and obligations.
Fully Delegated Subcontractor	A Subcontractor that contractually assumes all duties and obligations of CalOptima Health under the Contract, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Fully Delegated Subcontractor.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended commencing with Section 1340 of the California Health and Safety Code.
Health Network	For the purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network, either directly or through the use of subcontractors and downstream subcontractors that may be subject to the terms of this policy
Health Network Contract	For purposes of this policy, the applicable written instrument between CalOptima and a Health Network, for the purposes of providing delegated services to assigned Members. Health Network Contracts include the Contract for Health Care Services and the Medicare Advantage Service Agreement, including any and all amendments thereto.
Medical Loss Ratio (MLR)	The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Health Members by the total revenue received from CalOptima Health. Health Network medical costs would include incurred claims, expenditures for activities that improve healthcare quality, and fraud reduction activities.
Member	A beneficiary enrolled in a CalOptima Health program.
Network Provider	Covered California: Any Provider or entity that CalOptima Health has contracted with to deliver Covered Services for a specific network service area as defined in 28 CCR 1300.67.2.2(b)(10). Medi-Cal: Any Provider or entity that has a Network Provider Agreement with CalOptima Health or CalOptima Health's Subcontractor(s) and receives Medi-Cal funding directly or indirectly to order refer or render Covered Services under the contract between said parties. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.
Network Provider Agreement	A written agreement between a Network Provider and contractor, Subcontractor, or Downstream Subcontractor.

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Term	Definition
Partially Delegated Subcontractor	A Subcontractor that contractually assumes some, but not all, duties and obligations of CalOptima Health under the Contract, including, for example, obligations regarding specific Member populations or obligations regarding a specific set of services. Individual physician associations and medical groups often operate as Partially Delegated Subcontractors.
Physician Hospital Consortium (PHC)	A physician group or physician groups contractually aligned with at least one (1) hospital to provide Medi-Cal services to a common set of assigned Members, as described in CalOptima Health's Contract for Health Care Services.
Sanction	Action taken by CalOptima Health including, without limitations, restrictions, monetary fines, termination or a combination thereof, based on a Health Network's or its delegate's, subcontractor's, or any Health Network partner's failure to comply with statutory, regulatory, contractual, CalOptima Health policy, or other requirements related to the CalOptima Health Medi-Cal program.
Subcontractor	An individual or entity that has a Subcontractor Agreement with contractor that relates directly or indirectly to the performance of contractor's obligations under this contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.
Subcontractor Agreement	For the purposes of this policy, a written agreement between CalOptima Health or CalOptima Health's Subcontractor and a Subcontractor. The Subcontractor Agreement must include a delegation of CalOptima Health's duties and obligations.

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CalOptima Health Board Action Agenda Referral

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

Consent Calendar

5. Approve Actions Related to Covered California Administrative Services Agreements

Contact

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

Recommended Actions

To support the Department of Managed Health Care licensure filing process, authorize the Chief Executive Officer, or designee, to negotiate and execute contract amendments with specified vendors to update contract terms, as necessary, to expand services to the Covered California line of business and add payment terms and regulatory requirements.

Background

On October 3, 2024, the CalOptima Health Board of Directors (Board) directed the Chief Executive Officer to request the Orange County Board of Supervisors (BOS) amend CalOptima Health's enacting ordinance to remove the prohibition on participation in Covered California. On January 14, 2024, the BOS approved an amended ordinance to allow CalOptima Health to pursue a contract with Covered California.

On June 5, 2025, the Board authorized the Chief Executive Officer to initiate, submit, and complete a filing with the Department of Managed Health Care (DMHC) to expand CalOptima Health's current Knox-Keene Act license to operate a Covered California health plan. On June 16, 2025, CalOptima Health submitted the initial filing to DMHC to expand the scope of CalOptima Health's current Knox Keene Act license to enable CalOptima Health to offer a Covered California product.

The DMHC filing is a multi-phased process that CalOptima Health must complete by early 2026 to offer the Covered California product for benefit plan year 2027. The process requires the submission of many supporting exhibits that demonstrate compliance with the requirements of the Knox-Keene Act. Requirements include filing fully executed Administrative Service Agreements for vendors that will perform services for CalOptima Health's Covered California line of business.

Discussion

As part of CalOptima Health's delivery of services in the Covered California line of business, CalOptima Health proposes using current vendors who provide administrative services to create continuity in service and streamline administrative operations. CalOptima Health must submit administrative services contracts related to its proposed Covered California line of business to DMHC as part of the licensure review process. CalOptima Health must amend several administrative services contracts before submitting them to DMHC to ensure their duration includes the launch of the Covered California product in 2027 and that the scope includes the performance of activities for the Covered California line of business and the applicable Covered California and DMHC regulatory requirements.

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Adding Covered California to the Scope of Work

CalOptima Health needs to add the Covered California line of business and its associated regulatory requirements into the scope of work for each of the two administrative services contracts listed below. These contracts are for administrative services, including operation of a 24-hour nurse advice line and a broker portal tool. The two vendors are already supporting these functions for CalOptima Health's Medi-Cal and OneCare lines of business, as applicable.

The amendments needed to these contracts include the addition of Covered California as a program for which services would be provided and incorporation of Covered California and DMHC as regulators of the program and associated regulatory requirements. These vendor contracts extend beyond the start of CalOptima Health's Covered California program and do not require extension if the existing option years are exercised by CalOptima Health.

Vendor	Administrative Service	Current Contract Termination Dates & Extensions
Infomedia Group, Inc. dba Carenet Healthcare Services	Clinical Support for Behavioral Health Line and 24-Hour Nurse Advice Line	06/30/2027 plus two one-year extensions.
The Vital Group (Enthrive)	Broker Portal	12/31/2025 plus two one-year extensions.

In the event an administrative services contract included in this Board action is terminated prior to the effectuation of the provisions related to the addition of the Covered California line of business, staff will provide an update to the Board.

Fiscal Impact

The recommended actions have no additional impact. Funding for the recommended action will be included in the future Covered California operating budget or through separate Board action.

Rationale for Recommendation

The above recommended actions will support CalOptima Health's requirement to file all administrative services agreements with the Department of Managed Health Care (DMHC) in a timely fashion and ensure continuity of services during implementation of the new Covered California product.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *08/28/2025*
Authorized Signature **Date**

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Attachment #1 to the September 4, 2025, Board of Directors Meeting – Agenda Item 5

Covered California Administrative Services Agreements

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Infomedia Group, Inc. dba Carenet Healthcare Services	11845 IH 10 West, Suite 400	San Antonio	TX	78230
The Vital Group, LLC	23535 Palomino Dr., Suite 250	Diamond Bar	CA	91765

CalOptima Health Board Action Agenda Referral

Action To Be Taken September 4, 2025
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Consent Calendar

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

Contact

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

Recommended Action

Approve modifications to CalOptima Health Policy GA.5004: Travel and Other Reimbursable Expenses.

Background

CalOptima Health regularly reviews its policies and procedures to ensure they align with federal and state health care program requirements, contractual obligations, laws, and CalOptima Health operations.

Discussion

The CalOptima Health Board of Directors (Board) last approved modifications to this policy on November 2, 2023. The Policy provides guidance on reimbursable business-related expenses, including travel, transportation, catering and meals, lodging, professional licenses and membership dues, and public activities. Because this policy applies to Board members, standing committee members, employees, contractors, and others who conduct business on CalOptima Health's behalf, staff seeks Board approval of the proposed policy changes.

The table below outlines the substantive changes to Policy GA.5004 that are reflected in the attached redline policy. The list does not include non-substantive changes that may also be reflected in the redlined version of the policy (*i.e.*, formatting, spelling, punctuation, capitalization, minor clarifying language, or grammatical changes).

Section	Proposed Change	Rationale
II.C	Adds section for eligible travel reimbursements applicable to CalOptima Health's Board of Directors.	Establishes guidance on reimbursement eligibility for the Board of Directors.
II.D.1.d.ii	Removes section allowing remote teleworkers who began their workday at home to claim mileage reimbursement for travel to the central worksite.	Clarifies reimbursable mileage.
II.D.2.c.i	Adds "CalOptima Health will reimburse up to 125% of the GSA rate. If the nightly rates differ, the average nightly rate for the stay's duration should be calculated to determine if it is within the 125% threshold."	Provides additional guidance on the maximum reimbursable lodging rates.
II.D.2.c.ii	Adds "Lodging rates in excess of the 125% Federal GSA rate may be reimbursed with prior authorization from the CEO or CFO or if a conference provides a documented lodging discount as part of a group or	Provides additional guidance on allowable exceptions to the previous section.

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Section	Proposed Change	Rationale
	advance booking, and this rate exceeds the 125% threshold."	
II.D.3.b	Increases the maximum reimbursement for travel meals from $80.00 to $92.00 per day.	Increases limit to account for the impact of inflation.
II.F.1.a.i	Adds "does not include team building events or off-site social venues."	Clarifies items that are not eligible for meal reimbursements.
III.B.2	Adds "Employees granted the exception to book their own airfare shall not use personal credit card points, as CalOptima Health does not reimburse for this method of booking."	Provides additional guidance on paying for travel arrangements.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The proposed changes to CalOptima Health Policy GA.5004: Travel and Other Reimbursable Expenses address pertinent changes, align policy with current operations, and provide greater clarity on reimbursable travel expenses and procedures.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Health Policy GA.5004: Travel and Other Reimbursable Expenses

/s/ Michael Hunn *08/29/2025*
Authorized Signature **Date**

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Policy:	GA.5004
Title:	**Travel and Other Reimbursable Expenses**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/2012
Revised Date:	
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy establishes a uniform standard and process for reasonable and equitable reimbursement of approved travel, Transportation, catering and meals, lodging, business-related professional licenses and membership dues, public activities, and other actual and necessary business-related expenses incurred by CalOptima Health Employees, Governing Body, Standing Committee Members, and authorized contractors and consultants while conducting authorized CalOptima Health Business.

II. POLICY

A. CalOptima Health shall comply with all applicable laws and regulations to provide and reimburse Authorized Individuals for business-related expenses, which includes travel, Transportation, catering and meals, lodging, business-related professional licenses and membership dues, public activities, and other actual and necessary business-related expenses. The Finance Department shall implement an approval and reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel, Transportation, meals, lodging, and miscellaneous expenses incurred by Authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal laws and regulations.

B. CalOptima Health shall reimburse Authorized Individuals for reasonable, actual, and necessary expenses incurred while conducting CalOptima Health Business. Reimbursements for CalOptima Health business-related expenses shall be made in accordance with the Internal Revenue Service's (IRS) requirements, particularly the rules for an accountable plan, which requires: (1) expenses to have a business connection; (2) expenses be adequately accounted for within a reasonable period of time; and (3) any excess reimbursement or allowance be returned within a reasonable period of time. Reimbursement may be authorized when there is a clear connection or nexus between the attendance of the individual at such activity or function and the performance of official duties for which such an individual is regularly employed.

C. CalOptima Health may reimburse travel and related expenses for its nine (9) voting members of the Board of Directors. A formal vote of the Board of Directors shall be required to approve any travel reimbursements that fall outside of the following defined activities:

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1. Attendance at meetings of the Board of Directors, its committees, and the Board's ad hoc meetings;

2. Participation in meetings of CalOptima Health's advisory committees; or

3. Engagements involving a CalOptima Health employee that are conducted as part of official CalOptima Health business.

~~C.~~D. Business-related expenses for travel while conducting CalOptima Health Business must be completed at the most reasonable cost based on the facts and circumstances surrounding the travel. This includes making reservations for air travel and other expenses as soon as possible to access better rates, avoiding peak travel times, and leveraging efficiency by combining multiple meetings and events whenever possible. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible. Reimbursable travel expenses include actual and necessary expenses, such as:

1. Transportation: Including, but not limited to, commercial carriers, rental vehicles, mileage for use of personal vehicles, taxis, recognized ride-share companies, shuttles, and public transit fares.

   a. In selecting the mode of Transportation, the Authorized Individual shall consider the distance of the final destination from the individual's home or primary workplace, business schedule, and the cost effectiveness of the various modes of Transportation.

   b. The Authorized Individual shall make Transportation arrangements as far in advance as possible using the most economical carrier, and the most economical departure point, within the selected mode of Transportation. A Saturday night stay may be required to obtain the lowest possible rate and may be authorized if the savings will reasonably offset the additional cost of meals, automobile rental and lodging.

      i. Authorized Individuals may, for personal convenience, travel to their final destination on an indirect route, or on an interrupted direct route, if approved in advance within the Travel and Training Authorization (TTA) form. An Authorized Individual shall pay any increase in Transportation fares based on indirect or interrupted direct travel routes. Any resulting excess travel time shall not be considered work time but shall be charged to the appropriate type of leave.

      ii. Additional expenses shall not be the responsibility of the Authorized Individual if, through no fault or control of the Authorized Individual, it is necessary to travel an indirect route, or an interrupted direct route. In such cases, additional time shall be considered work time and shall not be charged to any type of leave.

      iii. Whenever available, all Authorized Individuals shall travel via "Coach Class," or similar reduced fare accommodations. "Business Class" reservations shall not be used except in the event that "Coach Class" or similar reduced fare accommodations are unavailable, and departure time is critical to the nature of the reason for travel. Under no circumstances shall "First Class" travel be reserved, unless First or Business Class is shown to be cheaper than coach (proof of price is required for reimbursement).

      iv. Authorized Individuals requesting travel reservations shall not insist on any certain commercial carrier if using the specified carrier will result in a fare which is higher than the lowest available fare.

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v. Any deviation from the lowest available rate for commercial carriers shall be at the Authorized Individual's expense.

c. The Authorized Individual shall be responsible for necessary cancellation of travel reservations, in accordance with the respective ~~carrier's~~carriers' rules and time limits. CalOptima Health shall not reimburse Authorized Individuals for fees associated with the failure to cancel reservations within the established carrier's rules and time limits unless the failure was due to circumstances beyond the control of the Authorized Individual. The Authorized Individual must also inform the Procurement & Vendor Management Department of any such cancellations.

d. Use of Privately-Owned Vehicles

i. An Authorized Individual may use a privately-owned vehicle for travel if such use is more economical than the lowest-priced direct commercial carrier fare plus rental car expenses. The Authorized Individual must be licensed and shall carry liability insurance as required by the State of California, at the Authorized Individual's sole expense.

ii. CalOptima Health shall reimburse the use of privately-owned vehicles solely based on actual mileage at the IRS Standard Mileage Rate at the time of travel. The Authorized Individual shall report ~~the~~ total mileage ~~and separately provide the offset mileage, which is~~reduced by the round-trip mileage distance between their ~~home~~residence and their CalOptima Health central worksite, except in the following situations:

a) If a teleworker is classified as a Community Worker by Human Resources, CalOptima Health shall reimburse for the round-trip mileage from the teleworker's remote work location to the off-site location~~;~~.;

~~b) If a remote teleworker begins their business day at home, and then travels for member or provider business appointments or to the central worksite, CalOptima Health shall reimburse for the round-trip mileage from the teleworker's remote work location to the off-site location(s) (offset mileage is not required). Support for beginning the workday at home must be attached to the Expense Report;~~

~~c)~~b) If an Authorized Individual's scheduled workday begins and ends at the CalOptima Health central worksite, any required off-site travel during the day shall be reimbursed for the round-trip mileage from CalOptima Health's central worksite to the off-site location and back; or~~.~~

~~d)~~c) If an Authorized Individual is required to travel for a CalOptima Health function that occurs on a day where the Authorized Individual is not normally scheduled to work, CalOptima Health shall reimburse the round-trip mileage from the Authorized Individual's home to the CalOptima Health function's location.

iii. For Authorized Individuals who receive an automobile allowance pursuant to CalOptima Health Policy GA.8042: Supplemental Compensation, CalOptima Health will only reimburse actual mileage at the IRS Standard Mileage Rate for travel that exceeds a round-trip of 100 miles based on the distance of the final destination from the individual's primary worksite. Use of privately-owned vehicles within a round-trip of 100 miles or less per meeting or event based on the distance of the final destination from the individual's primary workplace is covered as part of the automobile allowance.

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iv. CalOptima Health shall not reimburse costs for fuel, automobile repairs, other automobile expense items, or traffic/parking citations.

v. If more than one Authorized Individual is traveling for CalOptima Health Business in the same personal vehicle, only one person shall be reimbursed for the use of a privately-owned vehicle.

vi. Travel shall be by the most practical direct route. Any person traveling by an indirect route shall assume any additional expense incurred.

vii. CalOptima Health shall compensate property damages to an Authorized Individual's automobile incurred without fault or cause on the part of the Authorized Individual up to two hundred fifty dollars ($250), or the amount of the deductible on the person's insurance policy, whichever is the lesser amount, for each accident.

e. Rental Automobiles

i. An Authorized Individual may rent an automobile when such rental is considered to be more advantageous to CalOptima Health than other means of Transportation.

ii. Advance reservations shall be made whenever possible. Reservations for the Authorized Individual and the vehicle rental agreement shall be made in the person's name, acting for CalOptima Health. i.e., John Doe, for CalOptima Health.

iii. Rental automobile approved classes are as follows:

a) Economy Class or equivalent: An Authorized Individual shall select an economy class vehicle whenever four (4) or fewer Authorized Individuals, including the driver, will be passengers in the rental automobile at any one time.

b) Mid-size Class or equivalent: An Authorized Individual may select a mid-size class vehicle in the event more than four (4) Authorized Individuals will be riding in the rental automobile at any one (1) time, or in the event an economy class vehicle is not available, and the nature of the travel requires immediate departure or if the cost is lower than that of an economy class (Documented support required).

c) Luxury Class or equivalent: Under no circumstances shall an individual select a luxury class vehicle.

f. Other Modes of Transportation

i. Taxi Fares or Shuttles: CalOptima Health shall reimburse taxi fares or shuttles when public Transportation is not practical or available. Examples include travel between hotel and place of business, between airport and hotel, and from one business to another. Fares for travel outside of business hours with no business purpose are considered personal and not reimbursable.

ii. Ride Sharing Company: CalOptima Health does not encourage the use of Ride Sharing Companies, such as Uber or Lyft. However, if no other modes of Transportation are available or economical, CalOptima Health will reimburse Ride Sharing Company fares. Authorized Individuals shall use Ride Sharing Companies at their own risk and discretion, with no liability to CalOptima Health, understanding the dangers of using

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such services. Customary and reasonable Transportation tips/gratuity may be reimbursed in accordance with Section II.F. Tips and Gratuities.

g. Costs associated with any personal travel made in conjunction with a business travel itinerary will be at the Authorized Individual's expense. Authorized Individuals are expected to be honest in reporting any personal travel plans made in conjunction with business travel, and the Authorized Individual shall document the incremental travel costs assessed to CalOptima Health in accordance with this policy.

2. Lodging

a. CalOptima Health shall reimburse the cost of a single occupancy room at an Approved Lodging Facility for Non-local Travel.

b. Reasonable lodging expenses will be allowed. Price is a factor when selecting lodging, and prudence and good stewardship should be used when selecting a lodging facility. Comparison shopping is encouraged~~,~~ and booking in advance with the conference coordinator or through online travel websites, as opposed to directly with the lodging facility, may provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

i. Tips and gratuities associated with lodging are at the discretion of the Authorized Individual and will not be reimbursed by CalOptima Health. Please see section II.F Tips and Gratuities.

c. Travelers should seek lodging rates (excluding taxes and fees) at or below the federal government's per diem rate. ~~If such rates are not available, a hotel's discounted government rate shall be allowed.~~ A schedule of federal lodging per diem rates is available on the U.S. General Services Administration (GSA) ~~website: https://www.gsa.gov/travel/plan-book/per-diem-rates.~~website: https://www.gsa.gov/travel.

~~i. Lodging rates in excess of either the GSA federal lodging per diem rates or the government rate are allowable if the lodging is in conjunction with approved CalOptima Health business.~~

i. CalOptima Health will reimburse up to 125% of the GSA rate. If the nightly rates differ, the average nightly rate for the stay's duration should be calculated to determine if it is within the 125% threshold. Evidence of the applicable GSA rate must be attached to the employee's expense report.

ii. Lodging rates in excess of the 125% Federal GSA rate may be reimbursed with prior authorization from the CEO or CFO or if a conference provides a documented lodging discount as part of a group or advance booking, and this rate exceeds the 125% threshold. Evidence of the discount must be attached to the employee's expense report.

d. CalOptima Health may maintain preferred rates with select hotels in the local area. Vendors and consultants conducting CalOptima Health Business who are required to stay overnight and are authorized to receive reimbursement for lodging expenses pursuant to a contract with CalOptima Health, should utilize these preferred hotels, if available. Authorized Individuals should contact a member of the Procurement & Vendor Management Department for information and a link to the reservations department of these preferred hotels.

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e. CalOptima Health may reimburse additional nights of lodging expenses for Non-local Travel if~~:~~ (with support):

i. It results in offsetting lower airfare; and

ii. The cost of returning ~~to~~ home or to the office at the conclusion of business exceeds the cost of lodging, rental automobile and meals for the additional stay.

f. Local Travel may qualify for an overnight stay, depending on time constraints. CalOptima Health may approve Local Travel lodging expenses if:

i. It is not practical or feasible for the Authorized Individual to return home due to extremely poor weather conditions; or

ii. Less than eight (8) hours will elapse from the time business is concluded on one (1) day to the time business is scheduled to reconvene on the following calendar day.

g. Once approved, the Authorized Individual or their Designee shall be responsible for making his or her own travel and lodging arrangements, utilizing the CalOptima Health travel services provider or another method approved by the Budget & Vendor Management Department.

h. The Authorized Individual shall be responsible for necessary cancellation of travel and lodging reservations in accordance with the respective rules and time limits. CalOptima Health shall not reimburse Authorized Individuals for fees associated with the failure to cancel reservations within the established rules and time limits unless the failure was due to circumstances beyond the control of the Authorized Individual. The Authorized Individual shall inform the Procurement & Vendor Management Department of any cancellations.

3. Travel Meals

a. Travel Meals are those food items consumed when traveling on CalOptima Health Business overnight and away from the primary workplace.

b. CalOptima Health may reimburse Authorized Individuals the actual cost of Travel Meals, including taxes and gratuity (up to a maximum of 20% of the Authorized Individual's meal) and excluding alcoholic beverages, in an amount not to exceed ~~eighty~~ninety-two dollars ($~~80~~92.00) per day.

i. When traveling in groups, Authorized Individuals shall pay for his or her own meal when possible. Exceptions approved by Executive Staff will require a notated split of the bill receipt, with each CalOptima Health staff submitting separate Expense Reports for their portion.

c. Under certain conditions, CalOptima Health may reimburse employees and Board or Committee members for Travel Meals that exceed the ~~eighty~~ninety-two dollars ($~~80~~92.00) per day limit. The employee or Board or Committee member shall submit a valid receipt for such Travel Meals along with a brief explanation of the expenditure which must meet the following conditions:

i. Extraordinary circumstances may cause it to be impractical or unfeasible for the Authorized Individual to stay within the established meal rates, and the Authorized

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Individual shall submit receipts for such meals with a brief explanation of the extraordinary expenditure.

ii. Expense Reports containing extraordinary meal expenditures shall require approval of the Chief Executive Officer (CEO), or their Designee.

d. CalOptima Health may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board or Committee member Travel Meal reimbursement rate.

e. For Local Travel reimbursement, see Section II.~~E~~F.1. of this policy.

4. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

a. Attendance shall be:

i. Limited to the minimum number of individuals necessary to carry out the business purpose as deemed appropriate by the designated approver as specified in this policy;

ii. For only those whose job tasks or responsibilities are directly related to the purpose of the travel; and

iii. Approved by the department head, Budget staff and Human Resources.

b. Payment of Fees

i. Fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of fees by CalOptima Health at the time the TTA form is prepared and will submit necessary registration information to the Procurement & Vendor Management Department.

ii. In the event an individual must personally pay for Registration Fees, the individual shall request reimbursement on an Expense Report with a pre-approved TTA form.

5. Miscellaneous expenses, including:

a. Insurance for rental vehicles;

b. Parking, Fees and Tolls (i.e., charges for toll roads and necessary parking);

c. Authorized local and long-distance telephone calls;

d. Baggage fees (tips are not reimbursable);

e. Internet or Wi-Fi charges for business-related communication;

f. Facsimiles;

g. Expenses in connection with the preparation of authorized company reports or correspondence; and

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h. Other unforeseen or unusual business-related expenses that are properly justified and substantiated.

6. The type of expenses or occurrences that do not qualify for travel reimbursement of expenses include, but are not limited to:

a. Attendance at social, civic, or charitable meetings or functions, which the person would attend regardless of his or her position;

b. Any expenditure or contributions related to political campaigning or charitable fundraisers or events;

c. Expenses for anyone other than the Authorized CalOptima Health Individual attending or participating in the activity or function;

d. The personal portion of any travel;

e. Entertainment expenses, including movies, sporting events, or concerts; or

f. Personal losses incurred while on CalOptima Health business.

~~D.~~E. Cash advances

1. Under normal circumstances, CalOptima Health shall not issue cash advances for travel expenses.

2. CalOptima Health may authorize cash advances on a limited basis if the traveling Authorized Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized travel expenses.

3. A member of the Executive Staff shall approve requests for cash advances for anticipated authorized travel.

4. When authorized, cash advances shall be based on an estimate of reasonable travel expenses, including Transportation, Business Meals, lodging and miscellaneous expenses, and shall have a limit of $1,000 unless approved in advance by the Chief Financial Officer (CFO).

5. Cash advances shall not be provided earlier than thirty (30) days prior to the scheduled travel date(s). Authorized Individuals receiving cash advances shall complete an Expense Report within sixty (60) days of when the Authorized Individual's expenses were paid or incurred, whichever occurs first. The Authorized Individual shall account for all expenses incurred while traveling on authorized CalOptima Health Business and shall indicate and remit any cash amounts due back to CalOptima Health within one hundred and twenty (120) days of when the expenses were paid or incurred in the event the cash advance was greater than actual authorized expenses. In the event the actual authorized expenses exceed the amount of the cash advance, cash amounts due the Authorized Individual will be processed in the next pay period. Failure to return unexpended cash advances or to account for all expenses incurred while traveling may result in corrective action, up to and including termination.

~~E.~~F. Trainings, Meeting, Local Conferences, or Regulatory Audits Meals:

1. CalOptima Health recommends Authorized Individuals conduct internal staff meetings, trainings, and regulatory audits during non-lunch hours. Based on the below criteria, CalOptima

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Health may reimburse or pay the reasonable cost of ~~meals~~one meal per participant for required meetings, trainings, local conferences or regulatory audits in an amount not to exceed twenty-five dollars ($25.00) per participant meal which includes the cost of delivery, gratuity, and service fees.

a. Expenditure and/or reimbursement with CalOptima Health funds shall be permitted for mandatory staff meetings, trainings, or regulatory audits, if such expenditures meet all ~~of~~ the following three (3) criteria:

~~i.~~ A required or mandatory, in-person, meeting, training, local conference, regulatory audit, or business activity (does not include team building events or off-site social venues) that ~~last~~lasts for a minimum of four (4) hours~~;~~

i. , excluding a~~). An~~ non-working lunch;

a) Supporting documentation shall include an agenda detailing the purpose and schedule of the meeting shall be provided with the request for reimbursement.

ii. Supporting documentation ~~for~~shall include the advance written approval of an Executive Director and or Chief, prior to the meeting, training, regulatory audit, or other business activity; and

iii. Supporting documents ~~for the Expense Report or check request, including~~shall include the meeting or training agenda and ~~list~~the listing of CalOptima Health participants that supports the $25.00 limit.

2. Under no circumstances or conditions will meals be permitted or reimbursed for social functions or events, including, but not limited to the following:

a. Holiday parties (with the exception of an organization-wide mandatory event);

b. Birthdays;

c. Baby showers;

d. Marriage celebrations;

e. Retirements;

f. Department-only employee appreciation or celebration;

g. Other personal employee celebrations;

h. Expenditures for alcoholic beverages, including related tax and tip;

i. Voluntary events or functions, including, but not limited to, employee lunch time and/or after work group outings, team building events, and/or other off-site social functions (with the exception of training and self-development programs established and/or approved by the Human Resources Department); or

j. Provider gifts.

~~F.~~G. Business Activity Meals

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1. CalOptima Health may provide reimbursement to CalOptima Health Employees for budgeted Business Meals with written approval from the CEO or CFO. The ~~per participant~~ meal limit is twenty-five dollars ($25) which includes the cost of delivery, gratuity, and services fees. CalOptima Health shall not reimburse the cost of meals for individuals not employed by CalOptima Health. ~~Business~~If there are other CalOptima Health employees at the business lunch, they must request separate receipts for their submission of an expense report. The business purpose must be indicated on the Expense Report.

~~G.~~H. Tips and Gratuities: CalOptima Health will provide reimbursement to the Authorized Individual for Tips and Gratuities up to twenty (20) percent of the total charge for allowable expenditures as long as the supporting receipt can be validated.

1. Tips and Gratuities for allowable expenditures include meals, ride-sharing, and food delivery. Supporting documentation of the total cost including tips and gratuities must be included for reimbursement requests.

2. CalOptima Health shall not reimburse Tips and Gratuities without a receipt and those paid in cash without acceptable documentation as proof of payment.

3. CalOptima Health shall not reimburse Tips and Gratuities related to, but not limited to, the following:

   a. Lodging-related services, such as housekeeping, valet, and bell desk; or

   b. Expenditures that are otherwise not reimbursable under this policy.

~~H.~~I. Public Activities and Community Events: CalOptima Health will reimburse budgeted expenses for public activities and community events that are held for CalOptima Health members and providers.

1. Authorized Individuals shall confirm sufficient budgeted funds are available for expenditures for the public activities or community events.

   2. Authorized Individual shall submit a purchase requisition in advance of the public activity or community event for projected expenditures.

   a. In circumstances where a purchase requisition is not possible, Authorized Individual shall obtain approval from the CEO or their Designee in accordance with the Policy AA.1223: Participation in Community Events by External Entities

   3. When catering meals, CalOptima Health recommends Authorized Individuals utilize one of CalOptima Health's contracted companies. Authorized Individuals shall contact a member of the Procurement & Vendor Management Department for information.

   4. Authorized Individuals shall include supporting documents of the event such as the agenda/event flyer when submitting an Expense Report.

~~I.~~J. Business-related Professional Licenses and Membership Dues: CalOptima Health may reimburse budgeted business-related professional licenses and membership dues that are required under CalOptima Health Policy GA.8033: License and Certification Tracking or are necessary for an Authorized Individual's job duties. ~~It is suggested to contact the Procurement & Vendor Management Department for information on the payment through the requisition process.~~

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~~J.~~K. CalOptima Health will not provide reimbursement for gift cards purchased for internal training, staff recognition events, department events, and/or social functions.

III. PROCEDURE

A. Travel and Training Authorization (TTA) Form

1. All travel requests and requests for anticipated reimbursement of related expenses must be submitted online by Authorized Individuals or their Designee using CalOptima Health's Intranet system (or similar system in place at the time the request is made), and shall include all actual or estimated expense amounts related to the request; and

2. Such requests shall be routed for approval based on the Authorized Individual's level, cost center, and whether the Authorized Individual is a CalOptima Health Employee according to the following:

   a. Individual Departments are responsible for including anticipated travel expenses in the Department's operating budget.

   b. Budgeted Expenses: All budgeted travel and miscellaneous expenses for Authorized Individuals must be approved by the appropriate level of CalOptima Health Senior Management, prior to travel expenses being incurred, according to the following:

Individual	**Approver**
Employee through Department Manager	Department Director
Department Director	Executive Staff
Executive Director	Departmental Chief or Designee
Departmental Chief Officers	CEO or Designee
Chief Executive Officer	CFO or Designee
Board Member/Standing Committee Member	CEO or Designee

   c. If expenses exceed the originally approved TTA, then a supplemental TTA is required to be attached as proof of budget availability.

   d. Non-Budgeted Expenses: Non-budgeted travel and miscellaneous expenses for Authorized Individuals may be approved if the expenditures are appropriated and authorized in accordance with CalOptima Health Policy GA.5003: Budget and Operations Forecasting, prior to travel expenses being incurred.

3. All requests shall be routed to the Human Resources Department ~~in order~~ to ~~track~~provide for tracking of the Authorized Individual's training.

4. The Procurement & Vendor Management Department shall review all requests to verify that requested expenses are budgeted, and that sufficient budgeted funds are available to cover the requested expenses.

5. The Authorized Individual or Designee shall receive an automatic e-mail after submitting their request, notifying them of the approval status, and providing a link to the electronic form to track approval progress.

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6. The Procurement & Vendor Management Department shall review, authorize for appropriate approvals, and notify the Authorized Individual or Designee that they may begin making travel arrangements if not already completed by the Budget & Vendor Management Department.

B. Travel and Training Arrangements

1. Authorizations that include event Registration Fees shall be pre-paid and processed by the Budget & Vendor Management Department, when possible. The Procurement & Vendor Management Department shall verify with the Authorized Individual or Designee that the registration has not been processed before proceeding with registration for the event.

2. The Authorized Individual or Designee shall make air travel arrangements through CalOptima Health's travel services provider which is done through CalOptima Health's administrative assistants. Arrangements should be made as far in advance as possible to minimize costs. Exceptions to using CalOptima Health's travel services provider are subject to approval by the Procurement & Vendor Management Department and will be reimbursed using an Expense Report. Employees granted the exception to book their own airfare shall not use personal credit card points, as CalOptima Health does not reimburse for this method of booking.

3. All other arrangements shall be made with the Authorized Individual's personal credit card.

C. Expense Reimbursement using an Expense Report

1. Authorized Individuals or Designees shall prepare and submit claims for reimbursement of travel and other Reimbursable Expenses through the online CalOptima Health Expense Report system with an access link available on CalOptima Health's InfoNet. or incurred, whichever occurs first. Once the Expense Report has been completed, the Authorized Individual shall review and submit the Expense Report within the system. The system allows for the electronic selection of an applicable TTA form and electronically routes the Expense Report for management approvals according to the Authorized Individual's home department based on the threshold amounts and corresponding management approval levels in the table below.

Threshold Up Through	**Approver**
$1,000	Manager and Senior Manager
Over $1,000	Director

Note: Designee authorization is not valid when self-approval would result.

2. Receipts

a. For each expense, the Authorized Individual or Designee shall include an original itemized receipt, if available, or other computer-generated or hand-written receipt, in the event the original receipt is unavailable. The receipt shall include line item details of all eligible charges being submitted for reimbursement. If an itemized food receipt is not available, then a worksheet providing the line items ordered, cost and name of restaurant is acceptable to accompany receipts in a summarized format.

b. In the event an original receipt is unavailable, CalOptima Health may accept alternative documentation for proof of purchase and/or payment, such as computer-generated receipts, hand-written receipts, and/or excerpt of credit card statement with a detailed description of the charges.

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c. Small sized receipts, such as credit card, gas and airline receipts, shall be attached to an 8.5 by 11-inch sheet of paper and attached as a document image.

d. Hotel receipts and other larger size receipts may be submitted in their original form.

i. Hotel receipts that have charges for food or non-alcoholic beverages should be notated in the meal category section on the Expense Report and removed from the lodging total. CalOptima Health shall reimburse room service charges and tips for food or beverage for a combined total up to twenty percent (20%).

ii. In-room movies are considered personal and not reimbursable.

e. In most instances, airfare for CalOptima Health Employees and Board members shall be prepaid by CalOptima Health. CalOptima Health contractors authorized to receive reimbursement for airfare, and employees and Board members for whom airfare was not prepaid for any reason, shall submit invoices for passenger receipts for reimbursement consideration through Accounts Payable.

f. If receipts cannot be obtained or have been lost, a statement to that effect shall be made on the Expense Report, along with an appropriate explanation. In the absence of a satisfactory explanation, CalOptima Health shall not reimburse the expense.

3. Completed and approved Expense Reports with supporting documentation shall be submitted to the Accounting Department in a timely manner, preferably within thirty (30) days of completion of travel, but in no event beyond sixty (60) days after the expense is paid or incurred. Expense Reports are paid with the next payroll processing cycle and included on the employee's payroll check.

4. No reimbursement shall be made for Expense Reports submitted beyond sixty (60) days after completion of travel or when the expenses were paid or incurred, whichever occurs first.

a. Authorized Individuals may request an exception to the submission deadline, which is subject to the review and approval by the Controller.

D. The Accounting Department shall:

1. Review submitted Expense Reports and supporting documentation for completeness;

a. During the review, Accounting shall contact the Authorized Individual to request any missing supporting documentation.

b. Accounting shall provide advance communication of any denied reimbursement claims.

c. An Authorized Individual may dispute denied reimbursement claims by providing a narrative and/or additional supporting documentation to be reviewed by the Controller.

2. Review expense codes for appropriate department and general ledger account numbers; and

3. Process payment for reimbursement as a non-taxable miscellaneous reimbursement.

E. The Procurement & Vendor Management Department shall:

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1. Provide travel reports to the CEO, Executive Staff and department directors, upon request. Such reports may include a summary of travel by department, purpose, cost, and number of Authorized Individuals per event;

2. Review details of statements/invoices received from the CalOptima Health travel services provider for accuracy ~~and reasonableness~~;

3. ~~Attach appropriate copies~~Maintain a database of completed TTA forms related to travel service provider invoice line items and shall submit ~~them~~supported monthly invoices to Accounts Payable for payment;

4. Review details of statements/invoices received from the credit card account ~~used by the Procurement & Vendor Management Department~~ to arrange attendance at conferences, trainings, and other events, and ~~to make~~for making authorized purchases; and

5. ~~Attach appropriate copies~~Maintain a database of ~~completed TTA forms related to~~approved credit card invoice travel and training line items and once reviewed, submit ~~them~~the supported invoices to Accounts Payable for payment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Bylaws of Orange County Health Authority dba Orange Prevention and Treatment Integrated Medical Assistance, Adopted December 6, 1994
B. California Government Code Section 53232.2
C. California Labor Code Section 2802
D. CalOptima Health Policy GA.1223: Participation in Community Events by External Entities
E. CalOptima Health Policy GA.5003: Budget and Operations Forecasting
F. CalOptima Health Policy GA.8033: License and Certification Tracking
G. CalOptima Health Policy GA.8042: Supplemental Compensation
H. Internal Revenue Service Publication 463
I. Title 26, Code of Federal Regulations §§ 1.62-2

VI. REGULATORY AGENCY APPROVAL(S)

Not Applicable

VII. BOARD ACTION(S)

Date	Meeting
09/06/2012	Regular Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors
11/02/2023	Regular Meeting of the CalOptima Health Board of Directors
	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

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Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2012	GA.5004	Travel Policy	Administrative
Revised	09/06/2012	GA.5004	Travel Policy	Administrative
Revised	03/01/2013	GA.5004	Travel Policy	Administrative
Revised	03/03/2022	GA.5004	Travel Policy	Administrative
Revised	12/01/2022	GA.5004	Travel and Business Meal Policy	Administrative
Revised	11/02/2023	GA.5004	Travel and Other Reimbursable Expenses	Administrative
Revised	10/01/2024	GA.5004	Travel and Other Reimbursable Expenses	Administrative
Revised		GA.5004	Travel and Other Reimbursable Expenses	Administrative

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IX. GLOSSARY

Term	Definition
Authorized Individual	Persons authorized to submit an Expense Report for reimbursement of travel, meal, lodging, or other allowable expenses, including: CalOptima Health Board members, CalOptima Health Standing Committee Members, CalOptima Health Employees, and individuals under contract to CalOptima Health for which the approved contract provides for reimbursement of travel and/or conference expenses.
Approved Lodging Facility	Any overnight sleeping facilities which offer a discounted government rate to authorized individuals traveling on behalf of CalOptima Health.
Business Meals	Breakfast, lunch, dinner, snacks, refreshments, and related tips and taxes where business is discussed between authorized CalOptima staff and industry peers or business associates over the course of a meal.
CalOptima Health Business	Activities or functions which a department head determines are directly related to or in support of the ordinary, necessary and/or required mission and business functions of CalOptima Health.
CalOptima Health Employees	Includes, but are not limited to, all full-time and part-time regular CalOptima Health employees, all temporary employees, interns, CalOptima Health Board members, and applicable contractors and consultants.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Executive Staff	Staff holding Executive level positions as designated by the Board of Directors.
Expense Report	Detailed and itemized report that tracks expenses incurred during the course of performing necessary job functions.
Governing Body	The Board of Directors of CalOptima Health.
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Health Board of Directors who provide advice and recommendations regarding the organization's investments.
Local Travel	Travel to a destination that is 50 miles or less away from the primary workplace or home and does not generally include an overnight stay.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Non-local Travel	Travel which is more than 50 miles away from the primary workplace or home and may require an overnight stay.
Non-Reimbursable Expenses	Expenses that are not a necessary part of or approved as part of the required travel. Commuting between a traveler's home and regularly assigned work location is not considered official business.
Parking, Fees and Tolls	Charges for ferries, bridges, tunnels, toll roads, and necessary parking.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima Health to advise its Board of Directors on issues impacting the CalOptima Health Provider community.

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Term	Definition
Registration Fees	Actual fees paid for registration to attend authorized conferences, seminars, conventions, trainings or meetings of professional societies or community organizations.
Reimbursable Expenses	Reimbursable expenses include but are not limited to the cost of travel, transportation, catering and meals, lodging, business-related professional licenses and membership dues, public activities, and other actual and necessary business -related expenses incurred by CalOptima Health Employees, Governing Body, Standing Committee Members, and authorized contractors and consultants while conducting authorized CalOptima Health Business.
Standing Committee Members	Non-Board and non-employee members of the CalOptima Health Investment Advisory Committee (IAC), Provider Advisory Committee (PAC), Member Advisory Committee (MAC), OneCare Connect MAC, and Whole Child Model Family Advisory Committee.
Transportation	Bus, rail or airfare, car rental, taxi, ride sharing, shuttle, parking fees, tolls, and mileage for use of personal vehicle.
Travel Meals	Travel Meals are those food items consumed when traveling on CalOptima Health business that is considered Non-local Travel.

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Policy:	GA.5004
Title:	**Travel and Other Reimbursable Expenses**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/2012
Revised Date:	
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy establishes a uniform standard and process for reasonable and equitable reimbursement of approved travel, Transportation, catering and meals, lodging, business-related professional licenses and membership dues, public activities, and other actual and necessary business-related expenses incurred by CalOptima Health Employees, Governing Body, Standing Committee Members, and authorized contractors and consultants while conducting authorized CalOptima Health Business.

II. POLICY

A. CalOptima Health shall comply with all applicable laws and regulations to provide and reimburse Authorized Individuals for business-related expenses, which includes travel, Transportation, catering and meals, lodging, business-related professional licenses and membership dues, public activities, and other actual and necessary business-related expenses. The Finance Department shall implement an approval and reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel, Transportation, meals, lodging, and miscellaneous expenses incurred by Authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal laws and regulations.

B. CalOptima Health shall reimburse Authorized Individuals for reasonable, actual, and necessary expenses incurred while conducting CalOptima Health Business. Reimbursements for CalOptima Health business-related expenses shall be made in accordance with the Internal Revenue Service's (IRS) requirements, particularly the rules for an accountable plan, which requires: (1) expenses to have a business connection; (2) expenses be adequately accounted for within a reasonable period of time; and (3) any excess reimbursement or allowance be returned within a reasonable period of time. Reimbursement may be authorized when there is a clear connection or nexus between the attendance of the individual at such activity or function and the performance of official duties for which such an individual is regularly employed.

C. CalOptima Health may reimburse travel and related expenses for its nine (9) voting members of the Board of Directors. A formal vote of the Board of Directors shall be required to approve any travel reimbursements that fall outside of the following defined activities:

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1. Attendance at meetings of the Board of Directors, its committees, and the Board's ad hoc meetings;

2. Participation in meetings of CalOptima Health's advisory committees; or

3. Engagements involving a CalOptima Health employee that are conducted as part of official CalOptima Health business.

D. Business-related expenses for travel while conducting CalOptima Health Business must be completed at the most reasonable cost based on the facts and circumstances surrounding the travel. This includes making reservations for air travel and other expenses as soon as possible to access better rates, avoiding peak travel times, and leveraging efficiency by combining multiple meetings and events whenever possible. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible. Reimbursable travel expenses include actual and necessary expenses, such as:

1. Transportation: Including, but not limited to, commercial carriers, rental vehicles, mileage for use of personal vehicles, taxis, recognized ride-share companies, shuttles, and public transit fares.

a. In selecting the mode of Transportation**,** the Authorized Individual shall consider the distance of the final destination from the individual's home or primary workplace, business schedule, and the cost effectiveness of the various modes of Transportation.

b. The Authorized Individual shall make Transportation arrangements as far in advance as possible using the most economical carrier, and the most economical departure point, within the selected mode of Transportation. A Saturday night stay may be required to obtain the lowest possible rate and may be authorized if the savings will reasonably offset the additional cost of meals, automobile rental and lodging.

i. Authorized Individuals may, for personal convenience, travel to their final destination on an indirect route, or on an interrupted direct route, if approved in advance within the Travel and Training Authorization (TTA) form. An Authorized Individual shall pay any increase in Transportation fares based on indirect or interrupted direct travel routes. Any resulting excess travel time shall not be considered work time but shall be charged to the appropriate type of leave.

ii. Additional expenses shall not be the responsibility of the Authorized Individual if, through no fault or control of the Authorized Individual, it is necessary to travel an indirect route, or an interrupted direct route. In such cases, additional time shall be considered work time and shall not be charged to any type of leave.

iii. Whenever available, all Authorized Individuals shall travel via "Coach Class," or similar reduced fare accommodations. "Business Class" reservations shall not be used except in the event that "Coach Class" or similar reduced fare accommodations are unavailable, and departure time is critical to the nature of the reason for travel. Under no circumstances shall "First Class" travel be reserved, unless First or Business Class is shown to be cheaper than coach (proof of price is required for reimbursement).

iv. Authorized Individuals requesting travel reservations shall not insist on any certain commercial carrier if using the specified carrier will result in a fare which is higher than the lowest available fare.

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v. Any deviation from the lowest available rate for commercial carriers shall be at the Authorized Individual's expense.

c. The Authorized Individual shall be responsible for necessary cancellation of travel reservations, in accordance with the respective carriers' rules and time limits. CalOptima Health shall not reimburse Authorized Individuals for fees associated with the failure to cancel reservations within the established carrier's rules and time limits unless the failure was due to circumstances beyond the control of the Authorized Individual. The Authorized Individual must also inform the Procurement & Vendor Management Department of any such cancellations.

d. Use of Privately-Owned Vehicles

i. An Authorized Individual may use a privately-owned vehicle for travel if such use is more economical than the lowest-priced direct commercial carrier fare plus rental car expenses. The Authorized Individual must be licensed and shall carry liability insurance as required by the State of California, at the Authorized Individual's sole expense.

ii. CalOptima Health shall reimburse the use of privately-owned vehicles solely based on actual mileage at the IRS Standard Mileage Rate at the time of travel. The Authorized Individual shall report total mileage reduced by the round-trip mileage distance between their residence and their CalOptima Health central worksite, except in the following situations:

a) If a teleworker is classified as a Community Worker by Human Resources, CalOptima Health shall reimburse for the round-trip mileage from the teleworker's remote work location to the off-site location;

b) If an Authorized Individual's scheduled workday begins and ends at the CalOptima Health central worksite, any required off-site travel during the day shall be reimbursed for the round-trip mileage from CalOptima Health's central worksite to the off-site location and back; or

c) If an Authorized Individual is required to travel for a CalOptima Health function that occurs on a day where the Authorized Individual is not normally scheduled to work, CalOptima Health shall reimburse the round-trip mileage from the Authorized Individual's home to the CalOptima Health function's location.

iii. For Authorized Individuals who receive an automobile allowance pursuant to CalOptima Health Policy GA.8042: Supplemental Compensation, CalOptima Health will only reimburse actual mileage at the IRS Standard Mileage Rate for travel that exceeds a round-trip of 100 miles based on the distance of the final destination from the individual's primary worksite. Use of privately-owned vehicles within a round-trip of 100 miles or less per meeting or event based on the distance of the final destination from the individual's primary workplace is covered as part of the automobile allowance.

iv. CalOptima Health shall not reimburse costs for fuel, automobile repairs, other automobile expense items, or traffic/parking citations.

v. If more than one Authorized Individual is traveling for CalOptima Health Business in the same personal vehicle, only one person shall be reimbursed for the use of a privately-owned vehicle.

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vi. Travel shall be by the most practical direct route. Any person traveling by an indirect route shall assume any additional expense incurred.

vii. CalOptima Health shall compensate property damages to an Authorized Individual's automobile incurred without fault or cause on the part of the Authorized Individual up to two hundred fifty dollars ($250), or the amount of the deductible on the person's insurance policy, whichever is the lesser amount, for each accident.

e. Rental Automobiles

i. An Authorized Individual may rent an automobile when such rental is considered to be more advantageous to CalOptima Health than other means of Transportation.

ii. Advance reservations shall be made whenever possible. Reservations for the Authorized Individual and the vehicle rental agreement shall be made in the person's name, acting for CalOptima Health. i.e., John Doe, for CalOptima Health.

iii. Rental automobile approved classes are as follows:

a) Economy Class or equivalent: An Authorized Individual shall select an economy class vehicle whenever four (4) or fewer Authorized Individuals, including the driver, will be passengers in the rental automobile at any one time.

b) Mid-size Class or equivalent: An Authorized Individual may select a mid-size class vehicle in the event more than four (4) Authorized Individuals will be riding in the rental automobile at any one (1) time, or in the event an economy class vehicle is not available, and the nature of the travel requires immediate departure or if the cost is lower than that of an economy class (Documented support required).

c) Luxury Class or equivalent: Under no circumstances shall an individual select a luxury class vehicle.

f. Other Modes of Transportation

i. Taxi Fares or Shuttles: CalOptima Health shall reimburse taxi fares or shuttles when public Transportation is not practical or available. Examples include travel between hotel and place of business, between airport and hotel, and from one business to another. Fares for travel outside of business hours with no business purpose are considered personal and not reimbursable.

ii. Ride Sharing Company: CalOptima Health does not encourage the use of Ride Sharing Companies, such as Uber or Lyft. However, if no other modes of Transportation are available or economical, CalOptima Health will reimburse Ride Sharing Company fares. Authorized Individuals shall use Ride Sharing Companies at their own risk and discretion, with no liability to CalOptima Health, understanding the dangers of using such services. Customary and reasonable Transportation tips/gratuity may be reimbursed in accordance with Section II.F. Tips and Gratuities.

g. Costs associated with any personal travel made in conjunction with a business travel itinerary will be at the Authorized Individual's expense. Authorized Individuals are expected to be honest in reporting any personal travel plans made in conjunction with

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business travel, and the Authorized Individual shall document the incremental travel costs assessed to CalOptima Health in accordance with this policy.

2. Lodging

a. CalOptima Health shall reimburse the cost of a single occupancy room at an Approved Lodging Facility for Non-local Travel.

b. Reasonable lodging expenses will be allowed. Price is a factor when selecting lodging, and prudence and good stewardship should be used when selecting a lodging facility. Comparison shopping is encouraged and booking in advance with the conference coordinator or through online travel websites, as opposed to directly with the lodging facility, may provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

i. Tips and gratuities associated with lodging are at the discretion of the Authorized Individual and will not be reimbursed by CalOptima Health. Please see section II.F Tips and Gratuities.

c. Travelers should seek lodging rates (excluding taxes and fees) at or below the federal government's per diem rate. A schedule of federal lodging per diem rates is available on the U.S. General Services Administration (GSA) website: https://www.gsa.gov/travel.

i. CalOptima Health will reimburse up to 125% of the GSA rate. If the nightly rates differ, the average nightly rate for the stay's duration should be calculated to determine if it is within the 125% threshold. Evidence of the applicable GSA rate must be attached to the employee's expense report.

ii. Lodging rates in excess of the 125% Federal GSA rate may be reimbursed with prior authorization from the CEO or CFO or if a conference provides a documented lodging discount as part of a group or advance booking, and this rate exceeds the 125% threshold. Evidence of the discount must be attached to the employee's expense report.

d. CalOptima Health may maintain preferred rates with select hotels in the local area. Vendors and consultants conducting CalOptima Health Business who are required to stay overnight and are authorized to receive reimbursement for lodging expenses pursuant to a contract with CalOptima Health, should utilize these preferred hotels, if available. Authorized Individuals should contact a member of the Procurement & Vendor Management Department for information and a link to the reservations department of these preferred hotels.

e. CalOptima Health may reimburse additional nights of lodging expenses for Non-local Travel if (with support):

i. It results in offsetting lower airfare; and

ii. The cost of returning home or to the office at the conclusion of business exceeds the cost of lodging, rental automobile and meals for the additional stay.

f. Local Travel may qualify for an overnight stay, depending on time constraints. CalOptima Health may approve Local Travel lodging expenses if:

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i. It is not practical or feasible for the Authorized Individual to return home due to extremely poor weather conditions; or

ii. Less than eight (8) hours will elapse from the time business is concluded on one (1) day to the time business is scheduled to reconvene on the following calendar day.

g. Once approved, the Authorized Individual or their Designee shall be responsible for making his or her own travel and lodging arrangements, utilizing the CalOptima Health travel services provider or another method approved by the Budget & Vendor Management Department.

h. The Authorized Individual shall be responsible for necessary cancellation of travel and lodging reservations in accordance with the respective rules and time limits. CalOptima Health shall not reimburse Authorized Individuals for fees associated with the failure to cancel reservations within the established rules and time limits unless the failure was due to circumstances beyond the control of the Authorized Individual. The Authorized Individual shall inform the Procurement & Vendor Management Department of any cancellations.

3. Travel Meals

a. Travel Meals are those food items consumed when traveling on CalOptima Health Business overnight and away from the primary workplace.

b. CalOptima Health may reimburse Authorized Individuals the actual cost of Travel Meals, including taxes and gratuity (up to a maximum of 20% of the Authorized Individual's meal) and excluding alcoholic beverages, in an amount not to exceed ninety-two dollars ($92.00) per day.

i. When traveling in groups, Authorized Individuals shall pay for his or her own meal when possible. Exceptions approved by Executive Staff will require a notated split of the bill receipt, with each CalOptima Health staff submitting separate Expense Reports for their portion.

c. Under certain conditions, CalOptima Health may reimburse employees and Board or Committee members for Travel Meals that exceed the ninety-two dollars ($92.00) per day limit. The employee or Board or Committee member shall submit a valid receipt for such Travel Meals along with a brief explanation of the expenditure which must meet the following conditions:

i. Extraordinary circumstances may cause it to be impractical or unfeasible for the Authorized Individual to stay within the established meal rates, and the Authorized Individual shall submit receipts for such meals with a brief explanation of the extraordinary expenditure.

ii. Expense Reports containing extraordinary meal expenditures shall require approval of the Chief Executive Officer (CEO), or their Designee.

d. CalOptima Health may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board or Committee member Travel Meal reimbursement rate.

e. For Local Travel reimbursement, see Section II.F.1. of this policy.

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4. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

    a. Attendance shall be:

        i. Limited to the minimum number of individuals necessary to carry out the business purpose as deemed appropriate by the designated approver as specified in this policy;

        ii. For only those whose job tasks or responsibilities are directly related to the purpose of the travel; and

        iii. Approved by the department head, Budget staff and Human Resources.

    b. Payment of Fees

        i. Fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of fees by CalOptima Health at the time the TTA form is prepared and will submit necessary registration information to the Procurement & Vendor Management Department.

        ii. In the event an individual must personally pay for Registration Fees, the individual shall request reimbursement on an Expense Report with a pre-approved TTA form.

5. Miscellaneous expenses, including:

    a. Insurance for rental vehicles;

    b. Parking, Fees and Tolls (i.e., charges for toll roads and necessary parking);

    c. Authorized local and long-distance telephone calls;

    d. Baggage fees (tips are not reimbursable);

    e. Internet or Wi-Fi charges for business-related communication;

    f. Facsimiles;

    g. Expenses in connection with the preparation of authorized company reports or correspondence; and

    h. Other unforeseen or unusual business-related expenses that are properly justified and substantiated.

6. The type of expenses or occurrences that do not qualify for travel reimbursement of expenses include, but are not limited to:

    a. Attendance at social, civic, or charitable meetings or functions, which the person would attend regardless of his or her position;

    b. Any expenditure or contributions related to political campaigning or charitable fundraisers or events;

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c. Expenses for anyone other than the Authorized CalOptima Health Individual attending or participating in the activity or function;

d. The personal portion of any travel;

e. Entertainment expenses, including movies, sporting events, or concerts; or

f. Personal losses incurred while on CalOptima Health business.

E. Cash advances

1. Under normal circumstances, CalOptima Health shall not issue cash advances for travel expenses.

2. CalOptima Health may authorize cash advances on a limited basis if the traveling Authorized Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized travel expenses.

3. A member of the Executive Staff shall approve requests for cash advances for anticipated authorized travel.

4. When authorized, cash advances shall be based on an estimate of reasonable travel expenses, including Transportation, Business Meals, lodging and miscellaneous expenses, and shall have a limit of $1,000 unless approved in advance by the Chief Financial Officer (CFO).

5. Cash advances shall not be provided earlier than thirty (30) days prior to the scheduled travel date(s). Authorized Individuals receiving cash advances shall complete an Expense Report within sixty (60) days of when the Authorized Individual's expenses were paid or incurred, whichever occurs first. The Authorized Individual shall account for all expenses incurred while traveling on authorized CalOptima Health Business and shall indicate and remit any cash amounts due back to CalOptima Health within one hundred and twenty (120) days of when the expenses were paid or incurred in the event the cash advance was greater than actual authorized expenses. In the event the actual authorized expenses exceed the amount of the cash advance, cash amounts due the Authorized Individual will be processed in the next pay period. Failure to return unexpended cash advances or to account for all expenses incurred while traveling may result in corrective action, up to and including termination.

F. Trainings, Meeting, Local Conferences, or Regulatory Audits Meals:

1. CalOptima Health recommends Authorized Individuals conduct internal staff meetings, trainings, and regulatory audits during non-lunch hours. Based on the below criteria, CalOptima Health may reimburse or pay the reasonable cost of one meal per participant for required meetings, trainings, local conferences or regulatory audits in an amount not to exceed twenty-five dollars ($25.00) per participant meal which includes the cost of delivery, gratuity, and service fees.

a. Expenditure and/or reimbursement with CalOptima Health funds shall be permitted for mandatory staff meetings, trainings, or regulatory audits, if such expenditures meet all the following three (3) criteria:

i. A required or mandatory, in-person, meeting, training, local conference, regulatory audit, or business activity (does not include team building events or off-site social venues) that lasts for a minimum of four (4) hours, excluding a non-working lunch;

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a) Supporting documentation shall include an agenda detailing the purpose and schedule of the meeting shall be provided with the request for reimbursement.

ii. Supporting documentation shall include the advance written approval of an Executive Director and or Chief, prior to the meeting, training, regulatory audit, or other business activity; and

iii. Supporting documents shall include the meeting or training agenda and the listing of CalOptima Health participants that supports the $25.00 limit.

2. Under no circumstances or conditions will meals be permitted or reimbursed for social functions or events, including, but not limited to the following:

a. Holiday parties (with the exception of an organization-wide mandatory event);

b. Birthdays;

c. Baby showers;

d. Marriage celebrations;

e. Retirements;

f. Department-only employee appreciation or celebration;

g. Other personal employee celebrations;

h. Expenditures for alcoholic beverages, including related tax and tip;

i. Voluntary events or functions, including, but not limited to, employee lunch time and/or after work group outings, team building events, and/or other off-site social functions (with the exception of training and self-development programs established and/or approved by the Human Resources Department); or

j. Provider gifts.

G. Business Activity Meals

1. CalOptima Health may provide reimbursement to CalOptima Health Employees for budgeted Business Meals with written approval from the CEO or CFO. The meal limit is twenty-five dollars ($25) which includes the cost of delivery, gratuity, and services fees. CalOptima Health shall not reimburse the cost of meals for individuals not employed by CalOptima Health. If there are other CalOptima Health employees at the business lunch, they must request separate receipts for their submission of an expense report. The business purpose must be indicated on the Expense Report.

H. Tips and Gratuities: CalOptima Health will provide reimbursement to the Authorized Individual for Tips and Gratuities up to twenty (20) percent of the total charge for allowable expenditures as long as the supporting receipt can be validated.

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1. Tips and Gratuities for allowable expenditures include meals, ride-sharing, and food delivery. Supporting documentation of the total cost including tips and gratuities must be included for reimbursement requests.

2. CalOptima Health shall not reimburse Tips and Gratuities without a receipt and those paid in cash without acceptable documentation as proof of payment.

3. CalOptima Health shall not reimburse Tips and Gratuities related to, but not limited to, the following:

   a. Lodging-related services, such as housekeeping, valet, and bell desk; or

   b. Expenditures that are otherwise not reimbursable under this policy.

I. Public Activities and Community Events: CalOptima Health will reimburse budgeted expenses for public activities and community events that are held for CalOptima Health members and providers.

1. Authorized Individuals shall confirm sufficient budgeted funds are available for expenditures for the public activities or community events.

2. Authorized Individual shall submit a purchase requisition in advance of the public activity or community event for projected expenditures.

   a. In circumstances where a purchase requisition is not possible, the Authorized Individual shall obtain approval from the CEO or their Designee in accordance with the Policy AA.1223: Participation in Community Events by External Entities.

3. When catering meals, CalOptima Health recommends Authorized Individuals utilize one of CalOptima Health's contracted companies. Authorized Individuals shall contact a member of the Procurement & Vendor Management Department for information.

4. Authorized Individuals shall include supporting documents of the event such as the agenda/event flyer when submitting an Expense Report.

J. Business-related Professional Licenses and Membership Dues: CalOptima Health may reimburse budgeted business-related professional licenses and membership dues that are required under CalOptima Health Policy GA.8033: License and Certification Tracking or are necessary for an Authorized Individual's job duties.

K. CalOptima Health will not provide reimbursement for gift cards purchased for internal training, staff recognition events, department events, and/or social functions.

III. PROCEDURE

A. Travel and Training Authorization (TTA) Form

1. All travel requests and requests for anticipated reimbursement of related expenses must be submitted online by Authorized Individuals or their Designee using CalOptima Health's Intranet system (or similar system in place at the time the request is made), and shall include all actual or estimated expense amounts related to the request; and

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2. Such requests shall be routed for approval based on the Authorized Individual's level, cost center, and whether the Authorized Individual is a CalOptima Health Employee according to the following:

   a. Individual Departments are responsible for including anticipated travel expenses in the Department's operating budget.

   b. Budgeted Expenses: All budgeted travel and miscellaneous expenses for Authorized Individuals must be approved by the appropriate level of CalOptima Health Senior Management, prior to travel expenses being incurred, according to the following:

Individual	**Approver**
Employee through Department Manager	Department Director
Department Director	Executive Staff
Executive Director	Departmental Chief or Designee
Departmental Chief Officers	CEO or Designee
Chief Executive Officer	CFO or Designee
Board Member/Standing Committee Member	CEO or Designee

   c. If expenses exceed the originally approved TTA, then a supplemental TTA is required to be attached as proof of budget availability.

   d. Non-Budgeted Expenses: Non-budgeted travel and miscellaneous expenses for Authorized Individuals may be approved if the expenditures are appropriated and authorized in accordance with CalOptima Health Policy GA.5003: Budget and Operations Forecasting, prior to travel expenses being incurred.

3. All requests shall be routed to the Human Resources Department to provide for tracking of the Authorized Individual's training.

4. The Procurement & Vendor Management Department shall review all requests to verify that requested expenses are budgeted, and that sufficient budgeted funds are available to cover the requested expenses.

5. The Authorized Individual or Designee shall receive an automatic e-mail after submitting their request, notifying them of the approval status, and providing a link to the electronic form to track approval progress.

6. The Procurement & Vendor Management Department shall review, authorize for appropriate approvals, and notify the Authorized Individual or Designee that they may begin making travel arrangements if not already completed by the Budget & Vendor Management Department.

B. Travel and Training Arrangements

1. Authorizations that include event Registration Fees shall be pre-paid and processed by the Budget & Vendor Management Department, when possible. The Procurement & Vendor Management Department shall verify with the Authorized Individual or Designee that the registration has not been processed before proceeding with registration for the event.

2. The Authorized Individual or Designee shall make air travel arrangements through CalOptima Health's travel services provider which is done through CalOptima Health's administrative assistants. Arrangements should be made as far in advance as possible to minimize costs.

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Exceptions to using CalOptima Health's travel services provider are subject to approval by the Procurement & Vendor Management Department and will be reimbursed using an Expense Report. Employees granted the exception to book their own airfare shall not use personal credit card points, as CalOptima Health does not reimburse for this method of booking.

3. All other arrangements shall be made with the Authorized Individual's personal credit card.

C. Expense Reimbursement using an Expense Report

1. Authorized Individuals or Designees shall prepare and submit claims for reimbursement of travel and other Reimbursable Expenses through the online CalOptima Health Expense Report system with an access link available on CalOptima Health's InfoNet. or incurred, whichever occurs first. Once the Expense Report has been completed, the Authorized Individual shall review and submit the Expense Report within the system. The system allows for the electronic selection of an applicable TTA form and electronically routes the Expense Report for management approvals according to the Authorized Individual's home department based on the threshold amounts and corresponding management approval levels in the table below.

Threshold Up Through	**Approver**
$1,000	Manager and Senior Manager
Over $1,000	Director

Note: Designee authorization is not valid when self-approval would result.

2. Receipts

a. For each expense, the Authorized Individual or Designee shall include an original itemized receipt, if available, or other computer-generated or hand-written receipt, in the event the original receipt is unavailable. The receipt shall include line item details of all eligible charges being submitted for reimbursement. If an itemized food receipt is not available, then a worksheet providing the line items ordered, cost and name of restaurant is acceptable to accompany receipts in a summarized format.

b. In the event an original receipt is unavailable, CalOptima Health may accept alternative documentation for proof of purchase and/or payment, such as computer-generated receipts, hand-written receipts, and/or excerpt of credit card statement with a detailed description of the charges.

c. Small sized receipts, such as credit card, gas and airline receipts, shall be attached to an 8.5 by 11-inch sheet of paper and attached as a document image.

d. Hotel receipts and other larger size receipts may be submitted in their original form.

i. Hotel receipts that have charges for food or non-alcoholic beverages should be notated in the meal category section on the Expense Report and removed from the lodging total. CalOptima Health shall reimburse room service charges and tips for food or beverage for a combined total up to twenty percent (20%).

ii. In-room movies are considered personal and not reimbursable.

e. In most instances, airfare for CalOptima Health Employees and Board members shall be prepaid by CalOptima Health. CalOptima Health contractors authorized to receive reimbursement for airfare, and employees and Board members for whom airfare was not

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prepaid for any reason, shall submit invoices for passenger receipts for reimbursement consideration through Accounts Payable.

f. If receipts cannot be obtained or have been lost, a statement to that effect shall be made on the Expense Report, along with an appropriate explanation. In the absence of a satisfactory explanation, CalOptima Health shall not reimburse the expense.

3. Completed and approved Expense Reports with supporting documentation shall be submitted to the Accounting Department in a timely manner, preferably within thirty (30) days of completion of travel, but in no event beyond sixty (60) days after the expense is paid or incurred. Expense Reports are paid with the next payroll processing cycle and included on the employee's payroll check.

4. No reimbursement shall be made for Expense Reports submitted beyond sixty (60) days after completion of travel or when the expenses were paid or incurred, whichever occurs first.

a. Authorized Individuals may request an exception to the submission deadline, which is subject to the review and approval by the Controller.

D. The Accounting Department shall:

1. Review submitted Expense Reports and supporting documentation for completeness;

a. During the review, Accounting shall contact the Authorized Individual to request any missing supporting documentation.

b. Accounting shall provide advance communication of any denied reimbursement claims.

c. An Authorized Individual may dispute denied reimbursement claims by providing a narrative and/or additional supporting documentation to be reviewed by the Controller.

2. Review expense codes for appropriate department and general ledger account numbers; and

3. Process payment for reimbursement as a non-taxable miscellaneous reimbursement.

E. The Procurement & Vendor Management Department shall:

1. Provide travel reports to the CEO, Executive Staff and department directors, upon request. Such reports may include a summary of travel by department, purpose, cost, and number of Authorized Individuals per event;

2. Review details of statements/invoices received from the CalOptima Health travel services provider for accuracy;

3. Maintain a database of completed TTA forms related to travel service provider invoice line items and shall submit supported monthly invoices to Accounts Payable for payment;

4. Review details of statements/invoices received from the credit card account to arrange attendance at conferences, trainings, and other events, and for making authorized purchases; and

5. Maintain a database of approved credit card invoice travel and training line items and once reviewed, submit the supported invoices to Accounts Payable for payment.

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IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Bylaws of Orange County Health Authority dba Orange Prevention and Treatment Integrated Medical Assistance, Adopted December 6, 1994
B. California Government Code Section 53232.2
C. California Labor Code Section 2802
D. CalOptima Health Policy GA.1223: Participation in Community Events by External Entities
E. CalOptima Health Policy GA.5003: Budget and Operations Forecasting
F. CalOptima Health Policy GA.8033: License and Certification Tracking
G. CalOptima Health Policy GA.8042: Supplemental Compensation
H. Internal Revenue Service Publication 463
I. Title 26, Code of Federal Regulations §§ 1.62-2

VI. REGULATORY AGENCY APPROVAL(S)

Not Applicable

VII. BOARD ACTION(S)

Date	Meeting
09/06/2012	Regular Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors
11/02/2023	Regular Meeting of the CalOptima Health Board of Directors
	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2012	GA.5004	Travel Policy	Administrative
Revised	09/06/2012	GA.5004	Travel Policy	Administrative
Revised	03/01/2013	GA.5004	Travel Policy	Administrative
Revised	03/03/2022	GA.5004	Travel Policy	Administrative
Revised	12/01/2022	GA.5004	Travel and Business Meal Policy	Administrative
Revised	11/02/2023	GA.5004	Travel and Other Reimbursable Expenses	Administrative
Revised	10/01/2024	GA.5004	Travel and Other Reimbursable Expenses	Administrative
Revised		GA.5004	Travel and Other Reimbursable Expenses	Administrative

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IX. GLOSSARY

Term	Definition
Authorized Individual	Persons authorized to submit an Expense Report for reimbursement of travel, meal, lodging, or other allowable expenses, including: CalOptima Health Board members, CalOptima Health Standing Committee Members, CalOptima Health Employees, and individuals under contract to CalOptima Health for which the approved contract provides for reimbursement of travel and/or conference expenses.
Approved Lodging Facility	Any overnight sleeping facilities which offer a discounted government rate to authorized individuals traveling on behalf of CalOptima Health.
Business Meals	Breakfast, lunch, dinner, snacks, refreshments, and related tips and taxes where business is discussed between authorized CalOptima staff and industry peers or business associates over the course of a meal.
CalOptima Health Business	Activities or functions which a department head determines are directly related to or in support of the ordinary, necessary and/or required mission and business functions of CalOptima Health.
CalOptima Health Employees	Includes, but are not limited to, all full-time and part-time regular CalOptima Health employees, all temporary employees, interns, CalOptima Health Board members, and applicable contractors and consultants.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Executive Staff	Staff holding Executive level positions as designated by the Board of Directors.
Expense Report	Detailed and itemized report that tracks expenses incurred during the course of performing necessary job functions.
Governing Body	The Board of Directors of CalOptima Health.
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Health Board of Directors who provide advice and recommendations regarding the organization's investments.
Local Travel	Travel to a destination that is 50 miles or less away from the primary workplace or home and does not generally include an overnight stay.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Non-local Travel	Travel which is more than 50 miles away from the primary workplace or home and may require an overnight stay.
Non-Reimbursable Expenses	Expenses that are not a necessary part of or approved as part of the required travel. Commuting between a traveler's home and regularly assigned work location is not considered official business.
Parking, Fees and Tolls	Charges for ferries, bridges, tunnels, toll roads, and necessary parking.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima Health to advise its Board of Directors on issues impacting the CalOptima Health Provider community.

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Term	Definition
Registration Fees	Actual fees paid for registration to attend authorized conferences, seminars, conventions, trainings or meetings of professional societies or community organizations.
Reimbursable Expenses	Reimbursable expenses include but are not limited to the cost of travel, transportation, catering and meals, lodging, business-related professional licenses and membership dues, public activities, and other actual and necessary business -related expenses incurred by CalOptima Health Employees, Governing Body, Standing Committee Members, and authorized contractors and consultants while conducting authorized CalOptima Health Business.
Standing Committee Members	Non-Board and non-employee members of the CalOptima Health Investment Advisory Committee (IAC), Provider Advisory Committee (PAC), Member Advisory Committee (MAC), OneCare Connect MAC, and Whole Child Model Family Advisory Committee.
Transportation	Bus, rail or airfare, car rental, taxi, ride sharing, shuttle, parking fees, tolls, and mileage for use of personal vehicle.
Travel Meals	Travel Meals are those food items consumed when traveling on CalOptima Health business that is considered Non-local Travel.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

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

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Kelly Giardina, MSG, CCM, Executive Director Clinical Operations, (657) 900-1013

Recommended Actions

Approve modifications to CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers, effective September 5, 2025.

Background/Discussion

CalOptima Health routinely reviews its policies and procedures to ensure alignment with federal and state health care program requirements, contractual obligations, applicable laws, and internal operations.

Below is a summary of the impacted policy, and a list of substantive changes, as reflected in the redlined version in Attachment 1. Non-substantiative changes (e.g. formatting, spelling, punctuation, capitalization, minor clarifying language, and/or grammatical edits) are not listed.

Policy GG.1500 outlines the process by which a provider or practitioner must obtain authorization for covered services for CalOptima Health Direct (COHD) or CalOptima Health Community Network (CHCN) members. This includes prior authorization, concurrent review, and retrospective review.

Key changes include:

- Integration with CalOptima Health Policy GG.1313: Coordination of Care for Transplant Members: Enhances coordination for transplant related requests.
- Alignment with Department of Health Care Services (DHCS) requirements: Ensures full compliance with DHCS requirements for retrospective reviews.
- Operational Update: Reduces the timeframe for submitting retrospective requests from 365 to 60 calendar days.

Section II.A.2.b.ii	Updated time limit for submission of a request for retrospective services from 365 to 60 calendar days.
Section II.4.a	Added language transferred from CalOptima Health Policy GG.1313: Coordination of Care for Transplant Members as follows: "4. Transplant Services: a. If the Member is enrolled in a Health Network, the Provider shall request authorization for Transplant evaluation services from CalOptima Health."

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Section III.E.1	Added language for retrospective authorizations to align with DHCS requirement for retrospective requests as follows: "A. Provider or Practitioner may request retrospective authorization review for Covered Services rendered to a member when circumstances prevent the Provider's or Practitioner's ability to obtain a Prior Authorization request. One of the following conditions applies: a. The Member has Other Health Coverage (OHC); b. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal or OneCare, as applicable, and CalOptima Health eligibility at the time of service; or c. The Member's medical condition requires additional, immediate medical need during a planned procedure."
Section III.E.2	Updated language to adhere to DHCS requirement for retrospective requests by adding the following: "Medical documentation must accompany the retrospective authorization request."
Section III. J.A-D	Added language transferred from CalOptima Health Policy GG.1313: Coordination of Care for Transplant Members as follows: "J. If a Health Network receives a request for authorization for a Transplant evaluation: A. The Health Network shall notify the Provider to request authorization from CalOptima Health and shall forward the request to CalOptima Health Utilization Management Department within one (1) working day after receipt. B. CalOptima Health or a Health Network shall authorize a referral to a transplant program that meets DHCS criteria for an evaluation within seventy-two (72) hours of the Member's Primary Care Provider (PCP) or specialist identifying the Member as a potential candidate for the MOT services and receiving all of the necessary information to make a referral or authorization as appropriate in accordance with DHCS All Plan Letter (APL) 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative. C. After receipt of the authorization, the DHCS-approved Transplant Center or the Designated Special Care Center shall complete the evaluation required to determine medical suitability, including candidacy and compliance, in order to qualify the Member for a Transplant. D. The Member's Health Network shall immediately notify CalOptima Health upon identification of a Member who is listed for a Solid Organ

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	Transplant at a DHCS-approved Transplant Center or a Designated Special Care Center or is approved for a Transplant."

Fiscal Impact

The recommended action to approve modifications to CalOptima Health Policy GG.1500 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2025-26 Operating Budget.

Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, staff recommends that the CalOptima Health Board of Directors approve and adopt revised CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers

/s/ Michael Hunn *08/28/2025*
Authorized Signature **Date**

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Policy:	GG.1500
Title:	**Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/*
Effective Date:	07/01/1997
Revised Date:	07/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☐ PACE

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I. PURPOSE

To define the process by which a Provider or Practitioner shall obtain authorization for Covered Services for a CalOptima Health Direct (COHD) or CalOptima Health Community Network (CHCN) Member, including Prior Authorization, Concurrent Review, and Retrospective Review.

II. POLICY

A. A Provider or Practitioner shall request Prior Authorization, Concurrent Review and Retrospective Review for Covered Services listed on the CalOptima Health Authorization Required List, available at www.caloptima.org, in accordance with this Policy, except as provided in CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

1. A Provider or Practitioner requests authorization for elective inpatient services, elective outpatient services, elective ancillary services, and post-stabilization services after an emergency admission, prior to rendering such Covered Services to a Member.

2. A Provider or Practitioner may request retrospective authorization review for Covered Services rendered to a Member when extenuating circumstances prevent the Provider's or Practitioner's ability to obtain a Prior Authorization request.

   a. One of the following conditions apply:

      i. The Member has Other Health Coverage (OHC); or

      ii. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal or OneCare, as applicable, and CalOptima Health eligibility at the time of service.

   b. Retrospective submission timeframe:

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i. For a OneCare Member as long as such request is made within sixty (60) calendar days after the initial date of service.

ii. For a Medi-Cal Member as long as such request is made within a reasonable established time limit, not to exceed ~~three hundred and sixty five~~sixty (~~365~~60) calendar days from the date of service.

3. A Provider or Practitioner requests authorization for Covered Services rendered to a Member who is retroactively eligible for the CalOptima Health program within one hundred twenty (120) calendar days after the Member's retroactive eligibility determination is available in the State of California Beneficiary Eligibility Verification System.

~~3.~~4. Transplant Services:

a. If the Member is enrolled in a Health Network, the Provider shall request authorization for Transplant evaluation services from CalOptima Health.

B. CalOptima Health shall ensure that clinical decision made related to coverage or denial of requested services due in whole or in part to Medical Necessity are consistent and based upon sound medical evidence, in accordance with CalOptima Health Policies GG.1508: Authorization and Processing of Referrals, and GG.1535: Utilization Review Criteria and Guidelines.

C. Contracted and Non-Contracted Emergency Service Providers

1. The attending emergency physician, or the Provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on CalOptima Health.

2. Emergency Services are not subject to Prior Authorization by CalOptima Health, and CalOptima Health shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. CalOptima Health shall follow the standard definition of a Prudent Layperson, acting reasonably, to determine that the presenting complaint might be an emergency.

a. The attending emergency physician, or the Provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on such Member's assigned Health Network or on CalOptima Health if such Member is a CalOptima Health Direct Member, whichever is applicable.

b. A plan health professional shall be available to the emergency room personnel treating the Member, for consultation and for general communication, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

C. A hospital shall notify CalOptima Health within twenty-four (24) hours of a Member's Initial Emergency Encounter in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

D. A Provider or Practitioner shall obtain authorization for the following services, in accordance with specified CalOptima Health policies:

1. Services for a Member who meets California Children's Services (CCS) eligibility criteria, in accordance with CalOptima Health Policy CalOptima Health Policy GG.1508: Authorization and Processing of Referrals;

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2. Medical Supplies, in accordance with CalOptima Health Policies GG.1401: Physician Administered Drug (PAD) Prior Authorization Process, GG.1508: Authorization and Processing of Referrals, and MA.6101: Coverage Determination;

3. Disposable incontinence supplies, in accordance with CalOptima Health Policy GG.1114: Authorization for Disposable Incontinence Supplies;

4. Durable Medical Equipment, in accordance with CalOptima Health Policy GG.1502: Criteria and Authorization for Durable Medical Equipment (DME), Excluding Wheelchairs;

5. Wheelchair rental, purchase, or repair, in accordance with CalOptima Health Policy GG.1531: Criteria and Authorization for Wheelchair Rental, Purchase, and Repair;

6. Non-emergency medical transportation and non-medical transportation, in accordance with CalOptima Health Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical;

7. Hospice services, in accordance with CalOptima Health Policy GG.1503: CalOptima Health Hospice Coverage and Authorization Requirements;

8. Pharmacy services, in accordance with CalOptima Health Policies GG.1401: Physician Administered Drug (PAD) Prior Authorization Process, and MA.6101: Coverage Determination; and

9. Applied Behavioral Analysis (ABA) services and Psychological Testing, in accordance with CalOptima Health Policies GG.1548: Authorization and Monitoring of Behavioral Health Treatment Services and GG.1549: Authorization for Psychological Testing for Mental Health Conditions.

E. A Provider or Practitioner may appeal CalOptima Health's utilization management (UM) decision, in accordance with CalOptima Health Policies GG.1510: Member Appeal Process, MA.9003: Standard Pre-Service Appeal, and MA.9004: Expedited Pre-Service Integrated Appeal.

F. For services that do not require a Prior Authorization, Providers, including Specialist Physicians, shall refer the Member to a contracted Provider, unless such Provider is unavailable in-network. Referrals to an out-of-network Provider shall be processed in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

1. For Sensitive Services, Members may access any Provider, including those who are out-of-network, as outlined in CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network.

G. CalOptima Health and its Health Networks shall establish a process to monitor the appropriate utilization of medical care and services delivered to Members and ensure that care is monitored, analyzed, and interventions are implemented upon the identification of under and over utilization patterns in accordance with CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring.

H. CalOptima Health shall ensure the Prior Authorization process for Covered Services is consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.

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I. CalOptima Health shall not require a Provider or Practitioner to request Prior Authorization for Covered Services specified in section III.I. of this policy and in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals section III.A.

III. PROCEDURE

A. A Provider or Practitioner shall verify a Member's eligibility as follows:

1. Medi-Cal and CalOptima Health eligibility: In accordance with CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification; and

2. OneCare: Contact the Automated Eligibility Verification System (AEVS) by calling (800) 456-2387 and document the Eligibility Verification Confirmation number (EVC).

B. A Provider or Practitioner, including Specialist Physician, shall adhere to the responsibilities outlined in CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities.

C. Authorization Requests

1. A Practitioner or Provider shall request the following authorizations in accordance with this Policy:

   a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.

   b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.

   c. Request for Retrospective Review subject to the limitations as described in CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

2. A Provider or Practitioner shall submit a fully completed Authorization Request Form (ARF) including physician signature or written physician order, as well as current medical documentation supporting the need for the requested services to the CalOptima Health UM Department by:

   a. Mail to: Attn Utilization Management Department
   CalOptima Health
   PO Box 11033
   Orange CA 92856;

   b. Facsimile at 714-246-8579; or

   c. Phone: 1-888-587-8088.

   d. A contracted Provider may submit a routine, ~~non-~~urgent, or retrospective authorization request online via CalOptima Health Provider Portal ~~Link~~. The contracted Provider must upload medical documentation to CalOptima Health Provider Portal~~Link~~ to support the Medical Necessity of the requested services.

3. If the request is urgent, the Provider or Practitioner must:

   a. Specify that the request is urgent on the ARF and fax to 714-338-3137;

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~~a.~~b. Submit as an urgent request via the CalOptima Health Provider Portal; or

~~b.~~c. Notify the CalOptima Health UM Department of the urgent request by telephone.

4. A hospital must submit the request for Prior Authorization and obtain approval from CalOptima Health prior to a Member's admission to inpatient status.

5. A contracted hospital shall notify CalOptima Health of a Member's inpatient admission within twenty-four (24) hours of the admission.

   a. All initial requests for an inpatient stay will be acknowledged within twenty-four (24) hours of receipt of the request by providing a CalOptima Health tracking number to the facility.

      i. A decision will be made on an initial request within seventy-two (72) hours of receipt of the request.

      ii. CalOptima Health may extend this time frame by up to fourteen (14) calendar days, under the following condition:

         a) Additional supporting clinical information is needed.

   b. Concurrent clinical review shall continue throughout the inpatient stay.

      i. If additional days are required a subsequent decision shall be made within seventy-two (72) hours of request or last covered day.

      ii. CalOptima Health may extend this time frame by up to fourteen (14) calendar days, under the following condition:

         a) Additional supporting clinical information is needed.

   c. CalOptima Health staff shall assist the hospital with timely Discharge Planning to facilitate transition for CalOptima Health Direct Members to the most appropriate level of care following facility discharge.

D. Prior Authorization Request

1. Medically Necessary Post-Stabilization Services from Contracted Providers and Non-Contracted Providers.

   a. A hospital must submit a Prior Authorization request for post-stabilization services when a Member who has received Emergency Services for an Emergency Medical Condition is determined to have reached medical stability, but requires additional, Medically Necessary inpatient Covered Services that are:

      i. Related to the Emergency Medical Condition; and

      ii. Provided to maintain, improve, or resolve the Member's stabilized medical condition.

   b. All requests and responses for a post stabilization authorization are required to be fully documented. Documentation must include but is not limited to:

      i. The date and time of the request;

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ii. The name of the health care Provider making the request; and

iii. The name of the CalOptima Health staff responding to the request.

c. A Prior Authorization request for Medically Necessary post-stabilization services shall consist of a phone call ~~completed and signed ARF~~ from the facility to CalOptima Health Utilization Management Department ~~clinician~~ and include the following information to provide sufficient information to make a decision regarding care within thirty (30) minutes for Medi-Cal:

i. Identifying information including, Member name, birthdate, CIN, and gender;

ii. Name and role of facility clinician requesting Prior Authorization, direct phone number and the name of facility;

iii. Nature of the emergency condition that has been stabilized;

iv. Medical documentation, to include at a minimum:

a) History and physical;

b) Vital signs;

c) Laboratory and/or radiology results;

d) Any available consultation notes; and

e) Physician progress notes.

v. Co-morbid conditions; and

vi. Medical reason for admission to the hospital including proposed treatment.

d. For a Member enrolled in the Medi-Cal program, CalOptima Health shall approve or deny a Provider's Prior Authorization request for post-stabilization services within thirty (30) minutes after receipt of request that fully complies with Section III.D.1.b. of this policy. If CalOptima Health fails to approve or deny such request within thirty (30) minutes, Medically Necessary post-stabilization services are deemed approved.

i. Notwithstanding Section III.D.1.c. of this Policy, pursuant to section 1300.71.4 of Title 28 of the California Code of Regulations, CalOptima Health may notify the Provider of the denial of such request prior to the commencement of the delivery or during the continuation of the delivery of post-stabilization services, provided that the disruption of such services (taking into account the time necessary to effect the Member's transfer or discharge) does not have an adverse impact on the efficacy of such services of the Member's medical condition.

ii. In the case where CalOptima Health denies such request and informs the Provider of its decision to transfer the Member to another Provider, the Health Network shall effectuate the transfer of the Member as soon as possible.

e. For a Member enrolled in the OneCare program, CalOptima Health shall approve or deny a Provider's Prior Authorization request for post-stabilization services within sixty (60)

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minutes after receipt of request that fully complies with Section III.E.1.b. of this Policy. If CalOptima Health does not respond to such request within sixty (60) minutes, Medically Necessary post-stabilization services are considered approved.

f. CalOptima Health shall pay for Medically Necessary hospital Emergency Services and post-stabilization services in accordance with CalOptima Health Policies FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible, and MA.3101: Claims Processing.

2. Medically Necessary Non-Urgent Care Following Emergency Room Exam

a. For a Member enrolled in Medi-Cal, CalOptima Health shall approve or deny a Prior Authorization request for non-urgent care following an exam in an emergency room within thirty (30) minutes after receipt of such request from a non-contracted Provider on behalf of a Member who has received Emergency Services. If CalOptima Health does not respond to such request within the required timeframe, Medically Necessary non-urgent care is deemed approved.

3. CalOptima Health staff shall assist the hospital with timely Discharge Planning to facilitate transition for CalOptima Health Direct Members to the most appropriate level of care following facility discharge.

E. Retrospective Authorization

1. A Provider or Practitioner may request retrospective authorization review for Covered Services rendered to a member when circumstances prevent the Provider's or Practitioner's ability to obtain a Prior Authorization request. One of the following conditions applies:

a. The Member has Other Health Coverage (OHC);

b. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal or OneCare, as applicable, and CalOptima Health eligibility at the time of service; or

c. The Member's medical condition requires additional, immediate medical need during a planned procedure.

~~1.~~2. Medical documentation must accompany the retrospective authorization request. A Provider or Practitioner may request retrospective authorization for Covered Services rendered to a Member by submitting the following to CalOptima Health's UM Department:

a. Fully completed ARF;

b. Evidence of OHC payment or denial, if applicable;

c. Facility services:

i. Itemized bill;

ii. History and physical;

iii. Discharge summary;

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iv. Progress notes;

v. Physician's orders;

vi. Operative report;

vii. Emergency Department report, if applicable; and

viii. Outpatient procedure report, if applicable.

d. Outpatient professional services;

e. Diagnosis related to services provided;

f. Current Procedural Technology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) codes;

g. Medical justification;

h. Progress notes; and

i. Procedure report.

~~2.~~3. CalOptima Health shall process a request for retrospective authorization within thirty (30) calendar days from receipt of the information that is reasonably necessary to make a determination in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals (Attachment A).

F. A Provider or Practitioner may request to modify an authorization prior to rendering services by contacting the CalOptima Health UM Department.

G. CalOptima Health shall process a request for authorization, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

H. CalOptima Health shall process a request for authorization of out-of-network and/or out-of-area services, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

I. Services Excluded from the Prior Authorization Process

1. No Prior Authorization is required for the following services:

a. Emergency services

b. Urgent care visits

c. Sensitive services (which include family planning)

d. Sexually transmitted disease services

e. Elective abortion

f. Minor consent services

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g. Human Immunodeficiency Virus (HIV) testing

h. Basic prenatal care services

i. Routine obstetrics services

j. Pediatric preventive services, including any recommended routine immunizations

k. Primary and preventive care services, including any recommended routine immunizations

2. Cancer Biomarker testing services for a Member who meets the following criteria, in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) (22-010: Cancer Biomarker Testing:

a. Advanced or metastatic stage 3 or 4 cancer; or

b. Cancer progression or recurrence in the member with advanced or metastatic stage 3 or 4 cancer.

c. A Provider or Practitioner shall submit:

i. For portal authorizations, when biomarker testing is requested, the Provider will attest to the Member having stage 3 or stage 4 cancer and request will be processed the.

ii. For fax authorizations where biomarker testing is requested, the Provider will attest to the stage 3 and 4 cancer diagnosis on the ARF.

J. If a Health Network receives a request for authorization for a Transplant evaluation:

A. The Health Network shall notify the Provider to request authorization from CalOptima Health and shall forward the request to CalOptima Health Utilization Management Department within one (1) working day after receipt.

B. CalOptima Health or a Health Network shall authorize a referral to a transplant program that meets DHCS criteria for an evaluation within seventy-two (72) hours of the Member's Primary Care Provider (PCP) or specialist identifying the Member as a potential candidate for the MOT services and receiving all of the necessary information to make a referral or authorization as appropriate in accordance with DHCS All Plan Letter (APL) 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative.

C. After receipt of the authorization, the DHCS-approved Transplant Center or the Designated Special Care Center shall complete the evaluation required to determine medical suitability, including candidacy and compliance, in order to qualify the Member for a Transplant.

D. The Member's Health Network shall immediately notify CalOptima Health upon identification of a Member who is listed for a Solid Organ Transplant at a DHCS-approved Transplant Center or a Designated Special Care Center or is approved for a Transplant.

IV. ATTACHMENT(S)

A. CalOptima Health Authorization Request Form (ARF) – Medi-Cal
B. CalOptima Health Authorization Request Form (ARF) – Behavioral Health Treatment

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C. CalOptima Health Authorization Request Form (ARF) – OneCare

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
B. CalOptima Health, Health Network Service Agreement
C. CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification
D. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible
E. CalOptima Health Policy GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program
F. CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities
G. CalOptima Health Policy GG.1114: Authorization for Disposable Incontinence Supplies
H. CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network
I. CalOptima Health Policy GG.1401: Physician Administered Drug (PAD) Prior Authorization Process
J. CalOptima Health Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs
K. CalOptima Health Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
L. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
M. CalOptima Health Policy GG.1510: Member Appeal Process
N. CalOptima Health Policy GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair
O. CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring
P. CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines
Q. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
R. CalOptima Health Policy GG.1548: Authorization and Monitoring of Behavioral Health Treatment (BHT) Services
S. CalOptima Health Policy GG.1549: ~~Authorization for~~ Psychological Testing for Mental Health Conditions
T. CalOptima Health Policy MA.3101: Claims Processing
U. CalOptima Health Policy MA.6101: Medicare Part D Coverage Determination
~~V. CalOptima Health Policy MA.9003: Standard Pre-Service Appeal~~
~~W.~~V. CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal
~~X.~~W. CalOptima Health Utilization Management Program
~~Y.~~X. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-006: Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 17-018)
~~Z.~~Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-010: Cancer Biomarker Testing
~~AA.~~Z. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-009: Post Stabilization Care Services
~~BB.~~AA. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-008: Immunization Requirements (Supersedes APLs 18-004 and 16-009)
~~CC.~~BB. Health and Safety Code, Sections 1363.5 and 1367.01
~~DD.~~CC. Title 22, California Code of Regulations, Sections 51003 and 51536
~~EE.~~DD. Title 28, California Code of Regulations, Section 1300.71.4
~~FF.~~EE. Title 42, United States Code, Section 139u-2(b)(2)(D)
~~GG.~~FF. Title 42, Code of Federal Regulations, Section 438.404(a) and 438.910(d)

VI. REGULATORY AGENCY APPROVAL(S)

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Date	Regulatory Agency	Response
03/10/2016	Department of Health Care Services (DHCS)	Approved as Submitted
04/28/2021	Department of Health Care Services (DHCS)	Approved as Submitted
08/23/2022	Department of Health Care Services (DHCS)	Approved as Submitted
09/27/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
09/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted
04/18/2024	Department of Health Care Services (DHCS)	File & Use

VII. BOARD ACTION(S)

Date	Meeting
06/03/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/1997	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	05/01/1999	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	07/01/2007	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	09/01/2011	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Care Providers	Medi-Cal
Revised	03/01/2012	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Care Providers	Medi-Cal
Revised	02/01/2015	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal
Revised	03/01/2015	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal
Revised	01/01/2016	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	06/01/2017	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	01/01/2018	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	03/01/2021	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	06/03/2021	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect

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Action	Date	Policy	Policy Title	Program(s)
Revised	06/01/2022	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare Connect
Revised	09/01/2022	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare Connect
Revised	12/31/2022	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	07/01/2023	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	08/01/2023	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	04/01/2024	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	07/01/2024	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	11/01/2024	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	07/01/2025	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare

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IX. GLOSSARY

Term	Definition
Applied Behavior Analysis (ABA)	Refers to the use of behavioral learning principles (i.e. behavior-consequence paradigm) to produce changes in behavior, specifically the development of skills in areas of need (e.g. language) and the reduction in maladaptive behaviors (e.g. aggression, self-injury). ABA therapy may be comprehensive in nature, teaching adaptive techniques to address multiple behavioral and functional concerns, or may be problem-focused and targeted towards addressing specifically identified problematic behaviors (e.g., aggression). (MCG Behavioral Health 21st Edition)
Authorized Representative	For the purposes of this policy, an individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423 (Subpart M), Part 422 (Subpart M), or Part 438 (Subpart F), as applicable, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request in dealing with any of the levels of the appeals process.
Authorization Request Form (ARF)	CalOptima Health's form to request authorization for Covered Services.
Autism Spectrum Disorder (ASD)	A developmental disability originating in the early development period and affecting social communication and behavior, which has been diagnosed in accordance with the Diagnostic and Statistical Manual, 5th Edition (DSM-5). ASD also includes diagnoses of Autistic Disorder, Pervasive Developmental Disorder Not Otherwise Specific (PDD-NOS), and Asperger Disorder that were made using DSM-IV criteria.
Biomarker Test	A diagnostic test, single or multigene, of an individual's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide treatment. Biomarkers, also called tumor markers, are substances found in higher-than-normal levels in the cancer itself, or in blood, urine, or tissues of some individuals with cancer. Biomarkers can determine the likelihood some types of cancer will spread. They can also help doctors choose the best treatment. For some cancers, certain tumor markers may be more helpful for staging than treatment planning.
CalOptima Health	For purposes of this policy, CalOptima Health means CalOptima Health Direct, including CalOptima Health Community Network (CHCN).
Concurrent Review	A review of Medical Necessity of an authorization request for the Member's treatment regimen that is already in place while the Member is currently in an acute or post-acute setting, or in an ongoing course of care in an outpatient or community setting.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

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Term	Definition
	Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services;

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Term	Definition
	13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services, and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.
Emergency Medical Condition	Medi-Cal: A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: 1. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2. Serious impairment to bodily function; 3. Serious dysfunction of any bodily organ or part; or 4. Death OneCare: A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy;

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Term	Definition
	2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	Medi-Cal: Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1). OneCare: Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), , physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Initial Emergency Encounter	A Member's presentation to the emergency department for outpatient Emergency Services or the Member's inpatient emergency admission, whichever comes first.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	A beneficiary enrolled in a CalOptima Health program.
Non-Contracted Provider	Medi-Cal: A Provider that is not obligated by written contract to provide Covered Services to a Member. OneCare: A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.

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Term	Definition
Out-of-Area	Outside of the Service Area.
Out-of-Network	Health Network: Outside of the selected Health Network's participating provider network within the Service Area. Provider [CalOptima Health]: A Provider that does not participate in CalOptima Health's Network.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	Medi-Cal: A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Prudent Layperson	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.
Psychological Testing	The use of standardized assessment tools to gather information relevant to a member's intellectual and psychological functioning. Psychological testing can be used to determine differential diagnosis and assess overall cognitive functioning related to a member's mental health or substance use status. Test results may have important implications for treatment planning.
Retrospective Review	The process of determining Medical Necessity after treatment has been given.

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Term	Definition
Sensitive Services	All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.
Specialist Physician	A physician who has obtained additional education/training in a focused clinical area and does not function as a Primary Care Provider.

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Policy:	GG.1500
Title:	**Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/*
Effective Date:	07/01/1997
Revised Date:	07/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☐ PACE

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I. PURPOSE

To define the process by which a Provider or Practitioner shall obtain authorization for Covered Services for a CalOptima Health Direct (COHD) or CalOptima Health Community Network (CHCN) Member, including Prior Authorization, Concurrent Review, and Retrospective Review.

II. POLICY

A. A Provider or Practitioner shall request Prior Authorization, Concurrent Review and Retrospective Review for Covered Services listed on the CalOptima Health Authorization Required List, available at www.caloptima.org, in accordance with this Policy, except as provided in CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

1. A Provider or Practitioner requests authorization for elective inpatient services, elective outpatient services, elective ancillary services, and post-stabilization services after an emergency admission, prior to rendering such Covered Services to a Member.

2. A Provider or Practitioner may request retrospective authorization review for Covered Services rendered to a Member when extenuating circumstances prevent the Provider's or Practitioner's ability to obtain a Prior Authorization request.

   a. One of the following conditions apply:

      i. The Member has Other Health Coverage (OHC); or

      ii. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal or OneCare, as applicable, and CalOptima Health eligibility at the time of service.

   b. Retrospective submission timeframe:

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i. For a OneCare Member as long as such request is made within sixty (60) calendar days after the initial date of service.

ii. For a Medi-Cal Member as long as such request is made within a reasonable established time limit, not to exceed sixty (60) calendar days from the date of service.

3. A Provider or Practitioner requests authorization for Covered Services rendered to a Member who is retroactively eligible for the CalOptima Health program within one hundred twenty (120) calendar days after the Member's retroactive eligibility determination is available in the State of California Beneficiary Eligibility Verification System.

4. Transplant Services:

a. If the Member is enrolled in a Health Network, the Provider shall request authorization for Transplant evaluation services from CalOptima Health.

B. CalOptima Health shall ensure that clinical decision made related to coverage or denial of requested services due in whole or in part to Medical Necessity are consistent and based upon sound medical evidence, in accordance with CalOptima Health Policies GG.1508: Authorization and Processing of Referrals, and GG.1535: Utilization Review Criteria and Guidelines.

C. Contracted and Non-Contracted Emergency Service Providers

1. The attending emergency physician, or the Provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on CalOptima Health.

2. Emergency Services are not subject to Prior Authorization by CalOptima Health, and CalOptima Health shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. CalOptima Health shall follow the standard definition of a Prudent Layperson, acting reasonably, to determine that the presenting complaint might be an emergency.

a. The attending emergency physician, or the Provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on such Member's assigned Health Network or on CalOptima Health if such Member is a CalOptima Health Direct Member, whichever is applicable.

b. A plan health professional shall be available to the emergency room personnel treating the Member, for consultation and for general communication, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

C. A hospital shall notify CalOptima Health within twenty-four (24) hours of a Member's Initial Emergency Encounter in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

D. A Provider or Practitioner shall obtain authorization for the following services, in accordance with specified CalOptima Health policies:

1. Services for a Member who meets California Children's Services (CCS) eligibility criteria, in accordance with CalOptima Health Policy CalOptima Health Policy GG.1508: Authorization and Processing of Referrals;

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2. Medical Supplies, in accordance with CalOptima Health Policies GG.1401: Physician Administered Drug (PAD) Prior Authorization Process, GG.1508: Authorization and Processing of Referrals, and MA.6101: Coverage Determination;

3. Disposable incontinence supplies, in accordance with CalOptima Health Policy GG.1114: Authorization for Disposable Incontinence Supplies;

4. Durable Medical Equipment, in accordance with CalOptima Health Policy GG.1502: Criteria and Authorization for Durable Medical Equipment (DME), Excluding Wheelchairs;

5. Wheelchair rental, purchase, or repair, in accordance with CalOptima Health Policy GG.1531: Criteria and Authorization for Wheelchair Rental, Purchase, and Repair;

6. Non-emergency medical transportation and non-medical transportation, in accordance with CalOptima Health Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical;

7. Hospice services, in accordance with CalOptima Health Policy GG.1503: CalOptima Health Hospice Coverage and Authorization Requirements;

8. Pharmacy services, in accordance with CalOptima Health Policies GG.1401: Physician Administered Drug (PAD) Prior Authorization Process, and MA.6101: Coverage Determination; and

9. Applied Behavioral Analysis (ABA) services and Psychological Testing, in accordance with CalOptima Health Policies GG.1548: Authorization and Monitoring of Behavioral Health Treatment Services and GG.1549: Authorization for Psychological Testing for Mental Health Conditions.

E. A Provider or Practitioner may appeal CalOptima Health's utilization management (UM) decision, in accordance with CalOptima Health Policies GG.1510: Member Appeal Process, MA.9003: Standard Pre-Service Appeal, and MA.9004: Expedited Pre-Service Integrated Appeal.

F. For services that do not require a Prior Authorization, Providers, including Specialist Physicians, shall refer the Member to a contracted Provider, unless such Provider is unavailable in-network. Referrals to an out-of-network Provider shall be processed in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

1. For Sensitive Services, Members may access any Provider, including those who are out-of-network, as outlined in CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network.

G. CalOptima Health and its Health Networks shall establish a process to monitor the appropriate utilization of medical care and services delivered to Members and ensure that care is monitored, analyzed, and interventions are implemented upon the identification of under and over utilization patterns in accordance with CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring.

H. CalOptima Health shall ensure the Prior Authorization process for Covered Services is consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.

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I. CalOptima Health shall not require a Provider or Practitioner to request Prior Authorization for Covered Services specified in section III.I. of this policy and in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals section III.A.

III. PROCEDURE

A. A Provider or Practitioner shall verify a Member's eligibility as follows:

1. Medi-Cal and CalOptima Health eligibility: In accordance with CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification; and

2. OneCare: Contact the Automated Eligibility Verification System (AEVS) by calling (800) 456-2387 and document the Eligibility Verification Confirmation number (EVC).

B. A Provider or Practitioner, including Specialist Physician, shall adhere to the responsibilities outlined in CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities.

C. Authorization Requests

1. A Practitioner or Provider shall request the following authorizations in accordance with this Policy:

   a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.

   b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.

   c. Request for Retrospective Review subject to the limitations as described in CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

2. A Provider or Practitioner shall submit a fully completed Authorization Request Form (ARF) including physician signature or written physician order, as well as current medical documentation supporting the need for the requested services to the CalOptima Health UM Department by:

   a. Mail to: Attn Utilization Management Department
   CalOptima Health
   PO Box 11033
   Orange CA 92856;

   b. Facsimile at 714-246-8579; or

   c. Phone: 1-888-587-8088.

   d. A contracted Provider may submit a routine, urgent, or retrospective authorization request online via CalOptima Health Provider Portal. The contracted Provider must upload medical documentation to CalOptima Health Provider Portal to support the Medical Necessity of the requested services.

3. If the request is urgent, the Provider or Practitioner must:

   a. Specify that the request is urgent on the ARF and fax to 714-338-3137;

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b. Submit as an urgent request via the CalOptima Health Provider Portal; or

c. Notify the CalOptima Health UM Department of the urgent request by telephone.

4. A hospital must submit the request for Prior Authorization and obtain approval from CalOptima Health prior to a Member's admission to inpatient status.

5. A contracted hospital shall notify CalOptima Health of a Member's inpatient admission within twenty-four (24) hours of the admission.

a. All initial requests for an inpatient stay will be acknowledged within twenty-four (24) hours of receipt of the request by providing a CalOptima Health tracking number to the facility.

i. A decision will be made on an initial request within seventy-two (72) hours of receipt of the request.

ii. CalOptima Health may extend this time frame by up to fourteen (14) calendar days, under the following condition:

a) Additional supporting clinical information is needed.

b. Concurrent clinical review shall continue throughout the inpatient stay.

i. If additional days are required a subsequent decision shall be made within seventy-two (72) hours of request or last covered day.

ii. CalOptima Health may extend this time frame by up to fourteen (14) calendar days, under the following condition:

a) Additional supporting clinical information is needed.

c. CalOptima Health staff shall assist the hospital with timely Discharge Planning to facilitate transition for CalOptima Health Direct Members to the most appropriate level of care following facility discharge.

D. Prior Authorization Request

1. Medically Necessary Post-Stabilization Services from Contracted Providers and Non-Contracted Providers.

a. A hospital must submit a Prior Authorization request for post-stabilization services when a Member who has received Emergency Services for an Emergency Medical Condition is determined to have reached medical stability, but requires additional, Medically Necessary inpatient Covered Services that are:

i. Related to the Emergency Medical Condition; and

ii. Provided to maintain, improve, or resolve the Member's stabilized medical condition.

b. All requests and responses for a post stabilization authorization are required to be fully documented. Documentation must include but is not limited to:

i. The date and time of the request;

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ii. The name of the health care Provider making the request; and

iii. The name of the CalOptima Health staff responding to the request.

c. A Prior Authorization request for Medically Necessary post-stabilization services shall consist of a phone call from the facility to CalOptima Health Utilization Management Department and include the following information to provide sufficient information to make a decision regarding care within thirty (30) minutes for Medi-Cal:

i. Identifying information including, Member name, birthdate, CIN, and gender;

ii. Name and role of facility clinician requesting Prior Authorization, direct phone number and the name of facility;

iii. Nature of the emergency condition that has been stabilized;

iv. Medical documentation, to include at a minimum:

a) History and physical;

b) Vital signs;

c) Laboratory and/or radiology results;

d) Any available consultation notes; and

e) Physician progress notes.

v. Co-morbid conditions; and

vi. Medical reason for admission to the hospital including proposed treatment.

d. For a Member enrolled in the Medi-Cal program, CalOptima Health shall approve or deny a Provider's Prior Authorization request for post-stabilization services within thirty (30) minutes after receipt of request that fully complies with Section III.D.1.b. of this policy. If CalOptima Health fails to approve or deny such request within thirty (30) minutes, Medically Necessary post-stabilization services are deemed approved.

i. Notwithstanding Section III.D.1.c. of this Policy, pursuant to section 1300.71.4 of Title 28 of the California Code of Regulations, CalOptima Health may notify the Provider of the denial of such request prior to the commencement of the delivery or during the continuation of the delivery of post-stabilization services, provided that the disruption of such services (taking into account the time necessary to effect the Member's transfer or discharge) does not have an adverse impact on the efficacy of such services of the Member's medical condition.

ii. In the case where CalOptima Health denies such request and informs the Provider of its decision to transfer the Member to another Provider, the Health Network shall effectuate the transfer of the Member as soon as possible.

e. For a Member enrolled in the OneCare program, CalOptima Health shall approve or deny a Provider's Prior Authorization request for post-stabilization services within sixty (60) minutes after receipt of request that fully complies with Section III.E.1.b. of this Policy. If

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CalOptima Health does not respond to such request within sixty (60) minutes, Medically Necessary post-stabilization services are considered approved.

f. CalOptima Health shall pay for Medically Necessary hospital Emergency Services and post-stabilization services in accordance with CalOptima Health Policies FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible, and MA.3101: Claims Processing.

2. Medically Necessary Non-Urgent Care Following Emergency Room Exam

a. For a Member enrolled in Medi-Cal, CalOptima Health shall approve or deny a Prior Authorization request for non-urgent care following an exam in an emergency room within thirty (30) minutes after receipt of such request from a non-contracted Provider on behalf of a Member who has received Emergency Services. If CalOptima Health does not respond to such request within the required timeframe, Medically Necessary non-urgent care is deemed approved.

3. CalOptima Health staff shall assist the hospital with timely Discharge Planning to facilitate transition for CalOptima Health Direct Members to the most appropriate level of care following facility discharge.

E. Retrospective Authorization

1. A Provider or Practitioner may request retrospective authorization review for Covered Services rendered to a member when circumstances prevent the Provider's or Practitioner's ability to obtain a Prior Authorization request. One of the following conditions applies:

a. The Member has Other Health Coverage (OHC);

b. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal or OneCare, as applicable, and CalOptima Health eligibility at the time of service; or

c. The Member's medical condition requires additional, immediate medical need during a planned procedure.

2. Medical documentation must accompany the retrospective authorization request. A Provider or Practitioner may request retrospective authorization for Covered Services rendered to a Member by submitting the following to CalOptima Health's UM Department:

a. Fully completed ARF;

b. Evidence of OHC payment or denial, if applicable;

c. Facility services:

i. Itemized bill;

ii. History and physical;

iii. Discharge summary;

iv. Progress notes;

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v. Physician's orders;

vi. Operative report;

vii. Emergency Department report, if applicable; and

viii. Outpatient procedure report, if applicable.

d. Outpatient professional services;

e. Diagnosis related to services provided;

f. Current Procedural Technology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) codes;

g. Medical justification;

h. Progress notes; and

i. Procedure report.

3. CalOptima Health shall process a request for retrospective authorization within thirty (30) calendar days from receipt of the information that is reasonably necessary to make a determination in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals (Attachment A).

F. A Provider or Practitioner may request to modify an authorization prior to rendering services by contacting the CalOptima Health UM Department.

G. CalOptima Health shall process a request for authorization, in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

H. CalOptima Health shall process a request for authorization of out-of-network and/or out-of-area services, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

I. Services Excluded from the Prior Authorization Process

1. No Prior Authorization is required for the following services:

a. Emergency services

b. Urgent care visits

c. Sensitive services (which include family planning)

d. Sexually transmitted disease services

e. Elective abortion

f. Minor consent services

g. Human Immunodeficiency Virus (HIV) testing

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h. Basic prenatal care services

i. Routine obstetrics services

j. Pediatric preventive services, including any recommended routine immunizations

k. Primary and preventive care services, including any recommended routine immunizations

2. Cancer Biomarker testing services for a Member who meets the following criteria, in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) (22-010: Cancer Biomarker Testing:

a. Advanced or metastatic stage 3 or 4 cancer; or

b. Cancer progression or recurrence in the member with advanced or metastatic stage 3 or 4 cancer.

c. A Provider or Practitioner shall submit:

i. For portal authorizations, when biomarker testing is requested, the Provider will attest to the Member having stage 3 or stage 4 cancer and request will be processed the.

ii. For fax authorizations where biomarker testing is requested, the Provider will attest to the stage 3 and 4 cancer diagnosis on the ARF.

J. If a Health Network receives a request for authorization for a Transplant evaluation:

A. The Health Network shall notify the Provider to request authorization from CalOptima Health and shall forward the request to CalOptima Health Utilization Management Department within one (1) working day after receipt.

B. CalOptima Health or a Health Network shall authorize a referral to a transplant program that meets DHCS criteria for an evaluation within seventy-two (72) hours of the Member's Primary Care Provider (PCP) or specialist identifying the Member as a potential candidate for the MOT services and receiving all of the necessary information to make a referral or authorization as appropriate in accordance with DHCS All Plan Letter (APL) 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative.

C. After receipt of the authorization, the DHCS-approved Transplant Center or the Designated Special Care Center shall complete the evaluation required to determine medical suitability, including candidacy and compliance, in order to qualify the Member for a Transplant.

D. The Member's Health Network shall immediately notify CalOptima Health upon identification of a Member who is listed for a Solid Organ Transplant at a DHCS-approved Transplant Center or a Designated Special Care Center or is approved for a Transplant.

IV. ATTACHMENT(S)

A. CalOptima Health Authorization Request Form (ARF) – Medi-Cal
B. CalOptima Health Authorization Request Form (ARF) – Behavioral Health Treatment
C. CalOptima Health Authorization Request Form (ARF) – OneCare

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V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
B. CalOptima Health, Health Network Service Agreement
C. CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification
D. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible
E. CalOptima Health Policy GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program
F. CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities
G. CalOptima Health Policy GG.1114: Authorization for Disposable Incontinence Supplies
H. CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network
I. CalOptima Health Policy GG.1401: Physician Administered Drug (PAD) Prior Authorization Process
J. CalOptima Health Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs
K. CalOptima Health Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
L. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
M. CalOptima Health Policy GG.1510: Member Appeal Process
N. CalOptima Health Policy GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair
O. CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring
P. CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines
Q. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
R. CalOptima Health Policy GG.1548: Authorization and Monitoring of Behavioral Health Treatment (BHT) Services
S. CalOptima Health Policy GG.1549: Psychological Testing for Mental Health Conditions
T. CalOptima Health Policy MA.3101: Claims Processing
U. CalOptima Health Policy MA.6101: Medicare Part D Coverage Determination
V. CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal
W. CalOptima Health Utilization Management Program
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-006: Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 17-018)
Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-010: Cancer Biomarker Testing
Z. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-009: Post Stabilization Care Services
AA. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-008: Immunization Requirements (Supersedes APLs 18-004 and 16-009)
BB. Health and Safety Code, Sections 1363.5 and 1367.01
CC. Title 22, California Code of Regulations, Sections 51003 and 51536
DD. Title 28, California Code of Regulations, Section 1300.71.4
EE. Title 42, United States Code, Section 139u-2(b)(2)(D)
FF. Title 42, Code of Federal Regulations, Section 438.404(a) and 438.910(d)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/10/2016	Department of Health Care Services (DHCS)	Approved as Submitted
04/28/2021	Department of Health Care Services (DHCS)	Approved as Submitted
08/23/2022	Department of Health Care Services (DHCS)	Approved as Submitted

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Date	Regulatory Agency	Response
09/27/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
09/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted
04/18/2024	Department of Health Care Services (DHCS)	File & Use

VII. BOARD ACTION(S)

Date	Meeting
06/03/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/1997	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	05/01/1999	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	07/01/2007	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	09/01/2011	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Care Providers	Medi-Cal
Revised	03/01/2012	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Care Providers	Medi-Cal
Revised	02/01/2015	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal
Revised	03/01/2015	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal
Revised	01/01/2016	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	06/01/2017	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	01/01/2018	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	03/01/2021	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	06/03/2021	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	06/01/2022	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare Connect

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Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2022	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare Connect
Revised	12/31/2022	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	07/01/2023	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	08/01/2023	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	04/01/2024	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	07/01/2024	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	11/01/2024	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	07/01/2025	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare

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IX. GLOSSARY

Term	Definition
Applied Behavior Analysis (ABA)	Refers to the use of behavioral learning principles (i.e. behavior-consequence paradigm) to produce changes in behavior, specifically the development of skills in areas of need (e.g. language) and the reduction in maladaptive behaviors (e.g. aggression, self-injury). ABA therapy may be comprehensive in nature, teaching adaptive techniques to address multiple behavioral and functional concerns, or may be problem-focused and targeted towards addressing specifically identified problematic behaviors (e.g., aggression). (MCG Behavioral Health 21st Edition)
Authorized Representative	For the purposes of this policy, an individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423 (Subpart M), Part 422 (Subpart M), or Part 438 (Subpart F), as applicable, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request in dealing with any of the levels of the appeals process.
Authorization Request Form (ARF)	CalOptima Health's form to request authorization for Covered Services.
Autism Spectrum Disorder (ASD)	A developmental disability originating in the early development period and affecting social communication and behavior, which has been diagnosed in accordance with the Diagnostic and Statistical Manual, 5th Edition (DSM-5). ASD also includes diagnoses of Autistic Disorder, Pervasive Developmental Disorder Not Otherwise Specific (PDD-NOS), and Asperger Disorder that were made using DSM-IV criteria.
Biomarker Test	A diagnostic test, single or multigene, of an individual's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide treatment. Biomarkers, also called tumor markers, are substances found in higher-than-normal levels in the cancer itself, or in blood, urine, or tissues of some individuals with cancer. Biomarkers can determine the likelihood some types of cancer will spread. They can also help doctors choose the best treatment. For some cancers, certain tumor markers may be more helpful for staging than treatment planning.
CalOptima Health	For purposes of this policy, CalOptima Health means CalOptima Health Direct, including CalOptima Health Community Network (CHCN).
Concurrent Review	A review of Medical Necessity of an authorization request for the Member's treatment regimen that is already in place while the Member is currently in an acute or post-acute setting, or in an ongoing course of care in an outpatient or community setting.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

For 20250604 BOD Review Only

Term	Definition
	Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services;

For 202500

Term	Definition
	13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services, and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.
Emergency Medical Condition	Medi-Cal: A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: 1. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2. Serious impairment to bodily function; 3. Serious dysfunction of any bodily organ or part; or 4. Death OneCare: A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy;

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Term	Definition
	2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	Medi-Cal: Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1). OneCare: Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), , physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Initial Emergency Encounter	A Member's presentation to the emergency department for outpatient Emergency Services or the Member's inpatient emergency admission, whichever comes first.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	A beneficiary enrolled in a CalOptima Health program.
Non-Contracted Provider	Medi-Cal: A Provider that is not obligated by written contract to provide Covered Services to a Member. OneCare: A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.

For 20250904 BOD Review Only

Term	Definition
Out-of-Area	Outside of the Service Area.
Out-of-Network	Health Network: Outside of the selected Health Network's participating provider network within the Service Area. Provider [CalOptima Health]: A Provider that does not participate in CalOptima Health's Network.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	Medi-Cal: A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Prudent Layperson	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.
Psychological Testing	The use of standardized assessment tools to gather information relevant to a member's intellectual and psychological functioning. Psychological testing can be used to determine differential diagnosis and assess overall cognitive functioning related to a member's mental health or substance use status. Test results may have important implications for treatment planning.
Retrospective Review	The process of determining Medical Necessity after treatment has been given.

For 20250904 BOD Review Only

Term	Definition
Sensitive Services	All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.
Specialist Physician	A physician who has obtained additional education/training in a focused clinical area and does not function as a Primary Care Provider.

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For 20250904 BOD Review Only

P.O. BOX 11033 ORANGE, CA 92856 Phone: (714) 246-8686

AUTHORIZATION REQUEST FORM (ARF)

ROUTINE Fax to (714) 246-8579 PHARMACY MEDICATIONS Fax to (657) 900-1649 RETRO Fax to (714) 246-8579

***** IN ORDER TO PROCESS YOUR REQUEST ARF MUST BE COMPLETED AND LEGIBLE *****

PROVIDER: Authorization does not guarantee payment; ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ ☐ M ☐ F **D.O.B.** _____ **Age:** _____
Last First

Mailing Address: _____ **City:** _____ **ZIP:** _____ **Phone:** _____

Client Index # (CIN): _____ **Name of ICF/SNF (if applicable):** _____

Referring Provider:	**Provider Rendering Service (Physician, Facility, Vendor):**
Provider NPI#: _____ **TIN#:** _____	**Provider NPI#:** _____ **TIN#:** _____
Medi-Cal ID#: _____	**Medi-Cal ID#:** _____
Address: **Phone:** _____	**Address:** **Phone:** _____
Fax: _____	**Fax:** _____
Office Contact: _____	**Office Contact:**
Physician's Signature: _____	_____
Diagnosis: _____	**ICD-10:** _____

AUTHORIZATION REQUEST

☐ **URGENT REQUEST Fax to (714) 338-3137. ***Definition: "Urgent" is ONLY when normal time frame for authorization will be detrimental to patient's life or health, jeopardize patient's ability to regain maximum function, or result in loss of life, limb or other major bodily function. Urgent requests are addressed within 72 hours.*****

☐ **Inpatient** ☐ **Outpatient** ☐ **SNF** **Estimated Length of Stay:** _____

Date(s) of Services: _____ **Retro Date(s) of Service:** _____

List ALL procedures requested along with the appropriate CPT/HCPCS

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting Medical Records)	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)

Please check box below to indicate OK to change requested provider if required

☐ **OK to redirect to appropriate network provider. Allowing your member to be directed to a community provider will help the referral be processed faster and the member to be seen in a timelier manner.**

CalOptima Health

Medi-Cal

P.O. BOX 11033, ORANGE, CA 92856 **Phone: 855-877-3885**

Behavioral Health Treatment-Authorization Request Form (BHT-ARF)

(This form is for BHT services only)

Behavioral Health Fax: 714-954-2300

***** IN ORDER TO PROCESS YOUR REQUEST, BHT-ARF MUST BE COMPLETE AND LEGIBLE *****

PROVIDER: Authorization does not guarantee payment. ELIGIBILITY must be verified at the time services are rendered.

MEMBER INFORMATION			
Member Name (Last, First):		**Sex:** ☐ **M** ☐ **F** ☐ **Other:**	
Age:	**DOB:**	**Client Index # (CIN):**	**ICD-10 Dx:**
Mailing Address:		**Phone:**	

PROVIDER INFORMATION			
ABA Provider:			
Provider NPI:	**TIN:**	**Medi-Cal ID:**	
Address:	**Phone:**	**Fax:**	
Office Contact:	**Provider's Signature:**		

AUTHORIZATION REQUEST

List ALL procedures requested along with the appropriate CPT/HCPCS Code(s). Supporting documentation to include:

- Functional Behavior Assessment Report
- Treatment Plan/Progress Report
- Developmental and Diagnostic Evaluation
- PCP, Local Education Agency, ST/OT/PT Communications

REQUESTED PROCEDURES	HCPCS CODE	UNITS AND DURATION (typically 6 months)
Mental health assessment by non-physician	H0031	
Mental health service plan development by non-physician (Non-BCBA)	H0032-HN	
Mental health service plan development by non-physician (BCBA)	H0032-HO	
Skills training and development	H2014	
Therapeutic behavioral services	H2019	
Home care training to home care client	S5108	
Home care training, family	S5110	
Other		

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P.O. BOX 11033 ORANGE, CA 92856 Phone: 714- 246-8686

AUTHORIZATION REQUEST FORM (ARF)

☐ ROUTINE ☐ RETRO Pharmacy Medications Fax 657-900-1649 OneCare Fax 714-571-2440

*** IN ORDER TO PROCESS YOUR REQUEST, ARF MUST BE COMPLETE AND LEGIBLE ***

PROVIDER: Authorization does not guarantee payment. ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ ☐ M ☐ F D.O.B. _____ Age: _____
Last First

Mailing Address: _____ City: _____ ZIP: _____ Phone: _____

Client Index # (CIN): _____

Referring Provider:	Provider Rendering Service (Physician, Facility, Vendor):
Provider NPI#: _____ TIN#: _____ Medi-Cal ID#: _____	Provider NPI#: _____ TIN#: _____ Medi-Cal ID#: _____
Address: Phone: _____ Fax: _____	Address: Phone: _____ Fax: _____
Office Contact: _____ Physician's Signature: _____	Office Contact: _____
Diagnosis: _____	ICD-10: _____

AUTHORIZATION REQUEST

☐ URGENT REQUEST Fax to 714-571-2440. ***Definition: "Urgent" is ONLY when normal time frame for authorization will be detrimental to patient's life or health, jeopardize patient's ability to regain maximum function, or result in loss of life, limb or other major bodily function. Urgent requests are addressed within 72 hours.***

☐ Inpatient Facility ☐Outpatient Facility ☐ SNF:

Retro Date(s) of Service _____

List ALL procedures requested along with the appropriate CPT/HCPCS and Supporting Documentation

REQUESTED PROCEDURES	PERTINENT HISTORY (Submit supporting Medical Records)	CODE (CPT or HCPCS)	QUANTITY (REQUIRED)

CalOptima Health Board Action Agenda Referral

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

Consent Calendar

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

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Kelly Giardina, MSG, CCM, Executive Director Clinical Operations, (657) 900-1013

Recommended Actions

Approve modifications to CalOptima Health Policy GG.1508: Authorization and Processing of Referrals, effective September 5, 2025.

Background/Discussion

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

Below is a description of the impacted policy, followed by a list of substantive changes to the policy, which are reflected in redline policy included in Attachment 1. The list does not include non-substantive changes that may also be reflected in the redline (*e.g.*, formatting, spelling, punctuation, capitalization, minor clarifying language, and/or grammatical changes).

Policy GG.1508: Authorization and Processing of Referrals outlines the procedure by which CalOptima Health and its Health Networks process a request for prior authorization, concurrent review, and retrospective review of covered services for a member within the specified timeframes. The policy was last revised on June 1, 2025. The policy was revised to include the Department of Health Care Services' Requirements: Ensuring full compliance with the DHCS retrospective requests requirements

Policy Section	Change
Section II.L.3	Language added to require that a member must have an immediate medical need to be eligible for retrospective review for services provided during a planned procedure.
Section II.L.4.b	Updated time limit for submission of a request for retrospective services from 365 to 60 calendar days.

Fiscal Impact

The recommended action to approve modifications to CalOptima Health Policy GG.1508 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2025-26 Operating Budget.

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Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, staff recommends that the CalOptima Health Board of Directors approve and adopt revised CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals

/s/ Michael Hunn *08/28/2025*
Authorized Signature **Date**

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Policy:	GG.1508
Title:	**Authorization and Processing of Referrals**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/*
Effective Date:	01/01/1996
Revised Date:	07/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☐ PACE

For 20250904 BOD Review Only

I. PURPOSE

This policy establishes the procedure by which CalOptima Health and its Health Networks shall process a request for Prior Authorization, Concurrent Review, and Retrospective Review of Covered Services for a Member.

II. POLICY

A. CalOptima Health and its Health Networks shall process requests for Prior Authorization, Concurrent Review, and Retrospective Review within the timeframes specified in this Policy. CalOptima Health and its Health Networks shall maintain appropriate communication with the Member, the Member's Authorized Representative, and Practitioner or Provider, throughout the Prior Authorization process to facilitate delivery of appropriate services.

B. For Members enrolled in OneCare, CalOptima Health and its Health Networks shall ensure the authorization process for Covered Services is consistently applied.

1. Confirm the process of diagnoses or other medical criteria that are in the basis for coverage determinations for the specific item or service;

2. Basic benefits item or service is Medically Necessary; or

3. Supplemental benefits service or benefit is clinically appropriate.

C. For Members enrolled in OneCare, CalOptima Health or a Health Network, as applicable, shall accept an Organization Determination request from a Member or Member's Authorized Representative and shall not redirect the Member or Member's Authorized Representative to the Provider office to make such request.

1. If a OneCare Health Network Member calls CalOptima Health before contacting the Health Network regarding an authorization, CalOptima Health shall transfer such calls to the appropriate Health Network Customer Service line for assistance.

D. CalOptima Health and its Health Networks shall follow the applicable Timeframes for Decisions and Notifications Table, as set forth in Attachments A and B of this Policy, for all requested

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services, whether in- or out-of-network, as well as CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

E. CalOptima Health and its Health Networks shall ensure that clinical decision made related to coverage or denial of requested services due in whole or in part to Medical Necessity are consistent and based upon sound medical evidence, in accordance with CalOptima Health Policies GG.1535: Utilization Review Criteria and Guidelines, and GG.1541: Utilization Management Delegation.

F. With respect to the Whole Child Model (WCM) program, CalOptima Health and its Health Networks shall ensure compliance with applicable statutory, regulatory, and contractual requirements, as well as California Department of Health Care Services (DHCS) guidance, including, but not limited to, All Plan Letter (APL) 21-005: California Children's Services Whole Child Model Program, or any superseding APL. Without limiting the foregoing, CalOptima Health and the Health Networks shall:

1. Use all current and applicable California Children's Services (CCS) Program guidelines, including CCS Program regulations, CCS Program information notices, and CCS Numbered Letters in developing criteria for use by their respective medical director or the equivalent, and other care management staff.

2. Use evidenced-based guidelines or treatment protocols that are medically appropriate given the Member's CCS-Eligible Condition in cases in which applicable CCS clinical guidelines do not exist.

G. CalOptima Health and its Health Networks shall ensure the authorization process for Covered Services is consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.

H. CalOptima Health and its Health Networks must notify network providers of all services that require prior authorization, concurrent authorization or retrospective authorization.

I. CalOptima Health and the Health Networks shall make utilization management (UM) decisions based only on appropriateness of care and service, and existence of coverage. CalOptima Health and the Health Networks do not reward Practitioners or other individuals for issuing denial for coverage, care, or services. CalOptima Health and the Health Networks do not provide financial incentives to utilization management decision-makers to encourage decisions that result in underutilization.

J. CalOptima Health and the Health Networks shall not require a Provider or Practitioner to request Prior Authorization for Covered Services specified in Section III.A. of this Policy.

K. For services that do not require a Prior Authorization, Providers, including Specialist Physicians, shall refer the Member to a contracted Provider, unless such Provider is unavailable in-network. Referrals to an out-of-network Provider shall be processed in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

1. For Sensitive Services, Members may access any Provider, including those who are out-of-network, as outlined in CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network and in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 24-003: Abortion Services.

2. For Health Network Members, a Provider, including a Specialist Physician, shall follow the Health Network's authorization process.

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L. A Provider or Practitioner may request a retrospective authorization review for Covered Services rendered to a Member when extenuating circumstances prevent the Provider or Practitioner's ability to obtain a Prior Authorization request and when one (1) of the following conditions apply:

1. The Member has Other Health Coverage (OHC); ~~or~~

2. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal or OneCare, as applicable and CalOptima Health eligibility at the time of service; or ~~.~~

~~2.~~3. The Member's Medical condition requires additional, immediate medical need during a planned procedure.

~~3.~~4. Retrospective submission timeframe:

a. For a OneCare Member as long as such a request is made within sixty (60) calendar days after the initial date of service.

b. For a Medi-Cal Member as long as such a request is made within a reasonable established time limit, not to exceed ~~three hundred sixty-five~~sixty (~~365~~60) calendar days from the date of service.

M. CalOptima Health and a Health Network shall ensure that all contracted Providers and non-contracting Specialist Physicians and Providers are informed of the Prior Authorization and Referral process at the time of Referral.

N. CalOptima Health and its Health Networks that are responsible for utilization management of hospital services shall have a plan health professional or a contracting, qualified, and licensed physician available twenty-four (24) hours a day, seven (7) days a week to authorize Medically Necessary Post-Stabilization Care Services, to coordinate the transfer of stabilized Members in an emergency department if necessary, and for general communication with emergency room personnel.

O. CalOptima Health and its Health Networks shall provide coverage and payment, for hospital Emergency Services and Post Stabilization Care Services necessary to determine the presence or absence of an Emergency Medical Condition, and if an Emergency Medical Condition exists, for all services Medically Necessary to stabilize the Member's condition regardless of whether or not the request is from a contracted Provider, Non-Contracted Provider or Out-of- Network, as specified in Section III.D, E, and G of this Policy.

P. If a Member exhausts his or her Medicare benefits as provided under the OneCare Program, and at the request of the Health Network under a shared risk contract, CalOptima Health shall authorize Covered Services in accordance with this Policy or other applicable CalOptima Health policies and procedures.

Q. CalOptima Health and its Health Networks shall maintain a system for tracking and monitoring all Referrals for Provider and Member-requested (OneCare Members only) health care services and supplies requiring Prior Authorization as follows:

1. Referral turnaround time for issuing a determination;

2. Criteria used in making the determination;

3. If denied, deferred, or modified, a copy of the Notice of Action (NOA); and

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4. Specific services and supplies approved, denied, deferred, or modified, including classifying non-medical necessity denials.

III. PROCEDURE

A. Services Excluded from the Prior Authorization Process

1. For the Medi-Cal and OneCare programs, the following services do not require Prior Authorization:

a. Emergency Services or emergency care

i. CalOptima Health and its Health Networks shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

ii. CalOptima Health and its Health Networks shall follow the standard definition of a Prudent Layperson, acting reasonably, to determine that the presenting complaint might be an emergency.

iii. The attending emergency physician, or the Provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on such Member's assigned Health Network or on CalOptima Health if such Member is a CalOptima Health Direct Member, whichever is applicable.

b. Preventive and primary care services, including recommended routine immunizations;

c. Basic prenatal care;

d. Family Planning Services:

i. Health education and counseling necessary to make informed choices and to understand contraceptive methods;

ii. Limited history and physical examination for family planning services;

iii. Laboratory tests, if medically indicated, as part of the decision-making process for selecting a method of contraception;

iv. Diagnosis and treatment of sexually transmitted diseases (STDs), if medically indicated, during one (1) visit;

v. Screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and Referral for treatment;

vi. Provision of contraceptive pills, devices, and supplies;

vii. Follow-up care for complications associated with contraceptive methods issued by a family planning Provider or Practitioner;

viii. Tubal ligation;

ix. Vasectomies; and

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x. Pregnancy testing and counseling.

e. Routine obstetrical services; and

f. Elective abortions. *Non-emergency inpatient hospitalization for the performance of an abortion may require prior authorization.

i. CalOptima Health shall cover abortion services, as well as the medical services and supplies incidental or preliminary to an abortion.

ii. CalOptima Health shall not impose annual or lifetime limits on the coverage of outpatient abortion services.

g. Cancer Biomarker testing services for a Member who meets the following criteria, in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 22-010: Cancer Biomarker Testing:

i. Advanced or metastatic stage three (3) or four (4) cancer; or

ii. Cancer progression or recurrence in the Member with advanced or metastatic stage three (3) or stage four (4) cancer.

iii. For the CalOptima Health Direct and CalOptima Health Community Network programs, a Provider or Practitioner shall submit:

a) For portal authorizations, when biomarker testing is requested, the Provider will attest to the Member having stage three (3) or stage four (4) cancer and the request will be processed.

b) For fax authorizations where biomarker testing is requested, the Provider will attest to the stage three (3) and stage four (4) cancer diagnosis on the Authorization Request Form (ARF).

2. For the OneCare program, in addition to the services identified in Section III.A.1. of this Policy, the following services do not require Prior Authorization:

a. Services for Emergency Medical Conditions, including emergency Behavioral Health Care;

b. Urgent Care sought outside of the service area of Orange County, California;

c. Urgent Care under unusual and extraordinary circumstances provided in the service area of Orange County, California when the contracted medical provider is unavailable or inaccessible; and

d. Out-of-area renal dialysis services.

3. For the Medi-Cal Program, in addition to the services identified in Section III.A.1. of this policy, the following services do not require Prior Authorization:

a. Minor Consent Services: The following Minor Consent Services provided to a CalOptima Health Medi-Cal Member less than twenty-one (21) years of age do not require parental consent or Prior Authorization. Minor Consent Services are Covered Services of a sensitive nature related to:

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i. Sexual assault, including rape;

ii. Drug or alcohol abuse for a Member twelve (12) years of age or older;

iii. Pregnancy;

iv. Family Planning, including termination of pregnancy *Non-emergency inpatient hospitalization for the performance of an abortion may require prior authorization;

v. Sexually transmitted diseases (STDs) or HIV/AIDS for a Member twelve (12) years of age or older; and

vi. Non-Specialty Mental Health Services (NSMHS) for children ages twelve (12) and over who are deemed mature enough by the attending Professional Person to participate intelligently in their health car pursuant to Family Code Section 6924.

b. Initial mental health assessments; and

c. The Comprehensive Diagnostic Evaluation for assessment of Autism Spectrum Disorder.

B. Responsibilities of Primary Care Provider (PCP) and Specialist Physician

1. A PCP is required to maintain twenty-four (24) hour access for the Member, including availability for response to emergency and urgent questions from the Member in accordance with CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities. When possible, the PCP shall evaluate and counsel the Member and direct the Member to the most appropriate level of service based on the Member's condition.

2. All services shall be provided in the manner and time frames set forth in CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities.

3. Member Eligibility Verification

a. A Provider or Practitioner shall request basic information from a Member when providing services, including access to the Member's Medi-Cal Beneficiary Identification Card (BIC), Medicare identification card, or CalOptima Health identification card, or shall perform an eligibility verification using CalOptima Health's Provider Portal at www.caloptima.org.

b. Prior Authorization does not guarantee eligibility at the time services are rendered.

c. For Medi-Cal Members, a Provider or Practitioner shall verify eligibility at the time the services are provided, in accordance with CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification.

C. Authorization Requests

1. For a CalOptima Health Direct Member, a Practitioner or Provider shall request the following authorizations in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers:

a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.

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b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.

c. Request for Retrospective Review subject to the limitations described in Section II.L. of this Policy.

2. For a Health Network Member, a Practitioner or Provider shall request the following authorizations in accordance with the Health Network's authorization policy:

a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.

b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.

c. Request for Retrospective Review subject to the limitations described in Section II.L. of this policy.

3. An Urgent Authorization Request may be submitted if a routine authorization timeframe will be detrimental to a Member's life or health, jeopardize the Member's ability to regain maximum function, or may result in loss of life, limb, or other major body function. Such request is required to be decided within seventy-two (72) hours or as soon as the Member's health condition requires.

4. A hospital must submit the request for Prior Authorization and obtain approval from CalOptima Health or a Health Network, as applicable, for scheduled inpatient procedures prior to a Member's admission to inpatient status.

5. All CalOptima Health and Health Network authorization requests must include clinical records that validate the need for the requested item or service.

D. Hospital Notification of Emergency Services

1. A hospital shall notify CalOptima Health or the Member's Health Network, as applicable, within twenty-four (24) hours of a Member's Initial Emergency Encounter. Until a notification system is implemented, a hospital shall use best efforts to provide such notice within twenty-four (24) hours of the Member's presentation to the emergency department for outpatient Emergency Services.

2. If the Initial Emergency Encounter occurs on a holiday or weekend, notification to CalOptima Health or the Member's Health Network shall be made the following business day, or the time Member identity is known, or would have been known with the exercise of reasonable diligence.

E. Prior Authorization Request (Post-Stabilization Care Services)

1. Medically Necessary Post-Stabilization Care Services from Contracted Providers and Non-Contracted Providers

a. A hospital must request a Prior Authorization for Post-Stabilization Care Services when a Member who has received Emergency Services for an Emergency Medical Condition is determined to have reached medical stability, but requires additional, Medically Necessary inpatient Covered Services that are:

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i. Related to the Emergency Medical Condition; and

ii. Provided to maintain, improve, or resolve the Member's stabilized medical condition.

b. All requests and responses to a Post Stabilization Care Service request are required to be fully documented. Documentation shall include but is not limited to;

i. The date and time of the request;

ii. The name of the health care Provider making the request; and

iii. The name of the CalOptima Health or Health Network staff responding to the request.

c. A Prior Authorization request for Medically Necessary Post-Stabilization Care Services shall consist of a phone call from the facility to CalOptima Health or a Health Network's Utilization Management Department clinician and include the following information to provide sufficient information to make a decision regarding care within thirty (30) minutes for Medi-Cal and sixty (60) minutes for OneCare:

i. Identifying information including Member name, birthdate, CIN, and gender;

ii. Name and role of facility clinician requesting prior authorization, their direct phone number and the name of facility;

iii. Nature of the emergency condition that has been stabilized;

iv. Medical documentation to include at a minimum:

a) History and physical;

b) Vital signs; and

c) Laboratory and/or radiology results.

v. Co-morbid conditions; and

vi. Medical reason for admission to the hospital including proposed treatment.

d. For a CalOptima Health Direct Member enrolled in the Medi-Cal program, CalOptima Health shall process a Prior Authorization request for Medically Necessary Post-Stabilization Care Services in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers.

e. For a Health Network Member enrolled in the Medi-Cal program, the Health Network shall approve or deny a Provider's Prior Authorization request for Post-Stabilization Care Services within thirty (30) minutes after receipt of request that fully complies with Section III.E.1.a-c of this Policy. If the Health Network fails to approve or deny such request within thirty (30) minutes, Medically Necessary Post-Stabilization Care Services are deemed approved.

i Notwithstanding Section III.E.1.d. of this Policy, pursuant to Section 1300.71.4 of Title 28 of the California Code of Regulations, the Health Network may notify the Provider of the denial of such request prior to the commencement of the delivery or during the

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continuation of the delivery of Post-Stabilization Care Services, provided that the disruption of such services (taking into account the time necessary to effect the Member's transfer or discharge) does not have an adverse impact on the efficacy of such services or the Member's medical condition.

ii In the case where the Health Network denies such request and informs the Provider of its decision to transfer the Member to another Provider, the Health Network shall effectuate the transfer of the Member as soon as possible.

f. For a Health Network Member enrolled in the OneCare program, a Health Network shall approve or deny a Provider's Prior Authorization request for Post-Stabilization Care Services within sixty (60) minutes after receipt of request that fully complies with Section III.E.1a-c of this Policy. If the Health Network does not respond to such request within sixty (60) minutes, Medically Necessary Post-Stabilization Care Services are considered approved.

g. CalOptima Health and its Health Networks are also financially responsible for Post-Stabilization Care Services in the event that CalOptima Health or the Health Network:

i. Did not respond to a request for pre-approval within the timeframe allotted (Medi-Cal within thirty (30) minutes, OneCare within sixty (60) minutes);

ii. Could not be contacted; or

iii. Could not reach an agreement with the treating Provider concerning the Member's care and CalOptima Health or the Health Network physician was not available for consultation.

h. In the case where CalOptima Health or a Health Network and the treating Provider cannot reach an agreement concerning the Member's care and the CalOptima Health or Health Network physician is not available for consultation, CalOptima Health or the Health Network shall give the treating Provider the opportunity to consult with a CalOptima Health or Health Network physician and the treating Provider may continue with care of the Member until a CalOptima Health or the Health Network physician is reached or one (1) of the following criteria is met:

i. CalOptima or the Health Network physician with privileges at the treating Provider's hospital assumes responsibility for the Member's care;

ii. CalOptima Health or the Health Network physician assumes responsibility for the Member's care through transfer;

iii. CalOptima Health or the Health Network and the treating Provider reach an agreement concerning the Member's care; or

iv. The Member is discharged.

2. Medically Necessary Non-Urgent Care Following Emergency Room Exam

a. For a CalOptima Health Direct Member enrolled in the Medi-Cal program, CalOptima Health shall process a Prior Authorization request from a non-contracted Provider for Medically Necessary non-urgent care following an exam in the emergency room in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers.

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b. For a Health Network Member enrolled in the Medi-Cal program, a Health Network shall approve or deny a Prior Authorization request for non-urgent care following an exam in the emergency room within thirty (30) minutes after receipt of such request from a non-contracted Provider on behalf of a Member, who has received Emergency Services. If the Health Network does not respond to such request within the required timeframe, Medically Necessary non-urgent care is deemed approved.

3. Health Network staff shall assist the hospital with timely Discharge Planning to facilitate transition to the most appropriate level of care following facility discharge in accordance with the Health Network's policy.

F. Second Medical Opinions

1. A Member or the Member's Authorized Representative has the right to request a second opinion.

2. For Medi-Cal, a Member or the Member's Authorized Representative may request a second opinion from their Practitioner, or by contacting CalOptima Health's Customer Service Department (714-246-8500 or toll-free at 888-587-8088/TDD/TTY: 711), or the Member's Health Network.

3. For OneCare, a Member or the Member's Authorized Representative may request a second opinion from their Practitioner, or by contacting CalOptima Health's OneCare Customer Service Department (714-246-8711 or toll-free at 877-412-2734/TDD/TTY: 711), or the Member's Health Network.

4. CalOptima Health or a Health Network requires Prior Authorization for a second opinion by a Specialist Physician.

5. A Member may receive a second opinion from an in-network Provider at no cost. If an in-network Provider is not available, CalOptima Health or their Health Network shall make arrangements for the Member to obtain a second opinion from an out-of-network Provider at no cost.

6. A Member may receive a third opinion, at no cost to a Member, if there is a disparity between the initial and second opinion.

G. Out-of-Network Services

1. CalOptima Health or a Health Network shall provide Medically Necessary and Covered Services to a Member through an out-of-network Provider when CalOptima Health or the Health Network is unable to provide services within the network, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

2. CalOptima Health or a Health Network shall adequately and timely cover out-of-network services, for as long as CalOptima Health or the Health Network is unable to provide the services within the network. CalOptima Health or the Health Network shall process out-of-network service requests, as specified in the Timeframes for Decisions and Notifications Tables.

3. All requests requiring Prior Authorization shall require the requestor to submit a fully completed Authorization Request Form to CalOptima Health along with medical justification sufficient to make a determination and the physician signature. CalOptima Health shall process the request, as specified in the Timeframes for Decisions and Notifications Tables.

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4. CalOptima Health or a Health Network shall follow the Timeframes for Decisions and Notifications Tables for all requested services, whether in or out of the network.

5. CalOptima Health or a Health Network shall arrange for a Letter of Agreement (LOA) with an identified out-of-network Provider, in accordance with CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts.

6. CalOptima Health or a Health Network shall provide continued access as follows:

   a. For newly enrolled Medi-Cal beneficiaries, for up to twelve (12) months, to an out-of-network Provider with whom the Member has had an ongoing relationship if there are no quality-of-care issues with the Provider and the Provider accepts contracted or Medi-Cal rates in accordance with CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services.

   b. For Members eligible with the California Children's Services (CCS) Program and transitioned into the WCM program, for up to twelve (12) months, to an out-of-network CCS-paneled Provider, specialized or customized durable medical equipment provider, currently prescribed medication, and public health nurse, in accordance with CalOptima Health Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services, and GG.1330: Case Management – California Children's Services Program/Whole Child Model.

H. Denials, Deferrals, Dismissals, Terminations and Modifications of Prior Authorization Requests

1. In-Network Specialist Physician. CalOptima Health or a Health Network may redirect specialty care Prior Authorization requests to an in-network Specialist Physician under the following conditions:

   a. All modification, denial, dismissal, termination and notification requirements are followed pursuant to regulation requirements; and

   b. The in-network Specialist Physician is selected based on the following:

      i. A demonstrated ability to provide the services requested;

      ii. Prolific experience providing the services requested;

      iii. Volume of the requested care previously provided;

      iv. An existing relationship with CalOptima Health or the Health Network, as applicable;

      v. A proven ability to maintain adequate Member access;

      vi. A proven ability to provide care coordination;

      vii. No existing issues related to continuity of care or Tertiary service needs; and

      viii. For Members eligible with the CCS Program and transitioned into the WCM program, a CCS-paneled provider qualified to treat the CCS-Eligible Condition of the CCS child or youth, in accordance with CCS Program rules and regulations.

2. Consultation with Board-Certified Specialist.

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a. CalOptima Health may consult with a Board-Certified specialist if the Prior Authorization request is out of the scope of practice of the physician reviewer.

i. A CalOptima Health Medical Director shall forward a request for review by a Board-Certified specialist to the Prior Authorization manager or Designee for appropriateness;

ii. The Prior Authorization manager or Designee shall forward the request to a contracted external review agency electronically for review; and

iii. Upon receipt of the recommendation of the external review agency, the CalOptima Health Medical Director shall conduct the final review and determination.

b. The UMC shall maintain a list of Board-Certified specialists and will be reviewed annually by the Quality Improvement Committee (QIC).

3. Tertiary Care

a. CalOptima Health or a Health Network shall authorize Tertiary Care Services when a Member requires testing or treatment that is otherwise not available at a non-Tertiary level of care.

b. CalOptima Health shall only authorize Tertiary Care services under the following circumstances:

i. A Member requires testing or treatment that is otherwise not available at a non-Tertiary level of care;

ii. A Member requires interdisciplinary or simultaneous treatments with multiple specialty services as part of a complex, coordinated plan of care;

iii. A Member requires testing or treatment that is otherwise too high of a risk or otherwise not safe to perform at a non-Tertiary level of care;

iv. A Member or Provider requires a referral for experimental or investigational procedures not available in-network and may do so directly through CalOptima Health; and

v. There is no quality-of-care issues for the Provider.

4. Utilization Management (UM) Decision. CalOptima Health and its Health Networks shall ensure the following:

a. Requested health care services may be approved by UM staff who are not qualified health care professionals only when:

i. The UM staff is under the supervision of an appropriately licensed health professional;

ii. There are explicit UM criteria; and

iii. No clinical judgement is required.

b. Requested health care services which require the use of clinical judgement shall be approved by licensed health care professionals.

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c. Decisions to deny or to authorize an amount, duration, or scope less than the requested health care services shall be made by a qualified medical director with a current and unrestricted license to practice in California or other health care professional with appropriate clinical expertise in treating the condition and disease, including knowledge of Medicare and Medi-Cal coverage criteria.

i. Only a qualified, licensed physician or other qualified health care professional, as appropriate, shall deny or authorize an amount, duration, or scope less than the requested health care services based in whole or in part on Medical Necessity for any non-behavioral healthcare services.

ii. Only a qualified, licensed physician or appropriate behavioral healthcare practitioner as appropriate shall review and issue denials for Behavioral Health Care services for Medical Necessity or benefit coverage related to a Medi-Cal Member's behavioral health benefits; and

iii. Only a qualified, licensed physician or qualified, licensed clinical pharmacist shall review and approve, defer, modify or deny prior authorizations for pharmaceutical services.

d. Only qualified, licensed health care professionals supervise review decisions requiring Prior Authorization, including service reductions, and a qualified, licensed physician shall review all denials of a request for health care services based in whole or in part on Medical Necessity.

5. Notification of UM Decision

a. CalOptima Health and its Health Networks shall notify the requesting Practitioner or Provider and/or Member or Member's Authorized Representative, as appropriate, regarding any decision to deny, approve, modify, or delay an authorization request in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. In addition, for OneCare, CalOptima Health and its Health Networks shall ensure compliance with the notification requirements set forth in CalOptima Health Policy MA.6042: Integrated Organization Determinations.

b. If Medical Necessity criteria are not met, and review by a CalOptima Health or Health Network qualified licensed physician does not find the Member requires the requested inpatient level of care and Prior Authorization request is denied, delayed, modified, or alternative treatment is recommended, CalOptima Health or a Health Network shall notify the Member, the Member's Authorized Representative, and the Practitioner or Provider of the reason for the action.

i. CalOptima Health or the Health Network must provide auxiliary aids and services to a family member, friend, or associate of a Member if required by the ADA, including if the individual is identified as the Members' Authorized Representative, or is someone with whom it is appropriate for CalOptima Health or the Health Network to communicate.

ii. Communication needs of must be accommodated for all qualified Members with disabilities, including Authorized Representatives, and be prepared to facilitate alternate format requests for Braille, audio format, large print (no less than 20 point Arial font), and acceptable electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate, in accordance with CalOptima Health PolicyDD.2002: Cultural and Linguistic Services.

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c. For routine (non-urgent) authorization requests, if CalOptima Health or a Health Network does not take action by approving, denying, deferring, or modifying services, on a written request for Prior Authorization of Covered Services within fourteen (14) calendar days after receipt, such request shall be deemed denied by default and a notification of denial for the requested service shall be sent to the Provider and Member in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

I. Availability of CalOptima Health UM Staff and Services

1. CalOptima Health's UM Department shall provide Members or potential Members access to information about the UM process, and the process for authorizing care, in the Medi-Cal Member Handbook, and OneCare Evidence of Coverage available in-print and on the CalOptima Health website at www.caloptima.org.

2. CalOptima Health's UM Department shall provide Practitioners access to information about the UM process, and the process for authorizing care, in the Provider Manual, available on the CalOptima Health website at www.caloptima.org.

3. UM staff shall be available for inbound calls including toll free and collect calls, regarding UM issues during CalOptima Health normal business hours, Monday – Friday, from 8 a.m. to 5 p.m., with the exception of holidays. All inbound calls will be received by CalOptima Health's Customer Service Department and routed to appropriate UM staff.

   a. UM staff shall provide a toll-free number (and accept collect calls regarding UM issues.

   b. UM staff shall identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues.

   c. UM staff shall send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.

   d. UM staff shall be accessible to callers who have questions about the UM process.

   e. UM qualified, licensed physicians shall be available to answer denial determination questions during normal business hours and after hours calls regarding UM issues. During business hours, calls shall be directed to the UM Department and transferred to the appropriate UM physician. The after-hours answering service shall direct calls to the on-call physician.

   f. A UM physician shall respond to a treating Provider request within thirty (30) minutes for an emergency call and within one (1) business day for all other requests.

4. UM staff shall be available to receive inbound communication regarding UM issues after normal business hours through the on-call-service, facsimile, electronic, and telephone communications (e.g., sending e-mail messages or leaving voicemail messages). Communications received after normal business hours are returned on the next business day. Communications received after midnight on Monday-Friday are responded to on the same business day.

5. CalOptima Health shall utilize a telecommunications device for the deaf/telephone typewriter, or teletypewriter (TDD/TTY) services for deaf, hard of hearing or speech impaired, or comparable device or service available to assist Members, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic and Services (CalOptima Health is able to

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receive and send TDD/TYY messages and has a separate phone number for receiving TDD/TYY messages.).

6. CalOptima Health shall provide language assistance services free of charge to Members. CalOptima Health shall provide services in the requested language through bilingual staff or an interpreter, to assist Members with UM issues, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

7. CalOptima Health shall send a CalOptima Health Medi-Cal Member Handbook/Evidence of Coverage (EOC) booklet as part of the enrollment packet, as specified in CalOptima Health Policy DD.2005: Member-Informing Materials Requirements. The handbook will note the availability of UM staff in regard to UM issues and will include the Customer Service Department phone number and the TDD/TTY phone number.

8. Annually, CalOptima Health shall inform Medi-Cal Members of the availability of the CalOptima Health Member Handbook/Evidence of Coverage.

9. Annually, CalOptima Health shall send via U.S. Mail the OneCare Evidence of Coverage, for OneCare Members.

J. Failure of a Health Network or CalOptima Health department to comply with CalOptima Health's authorization policies and procedures, as applicable, as well as relevant statutory, regulatory, and/or contractual requirements, shall lead to disciplinary action which may include, but not be limited to, education and training on CalOptima Health's authorization process and reports to the Utilization Management Committee (UMC), Delegation Oversight Committee (DOC), and/or the Compliance Committee.

1. Continued non-compliance may lead to the issuance of a Corrective Action Plan (CAP) and/or Sanctions, in accordance with CalOptima Health Policies HH.2002: Sanctions and HH.2005: Corrective Action Plan.

IV. ATTACHMENT(S)

A. Timeframes for Medi-Cal Service Decisions and Notifications
B. Timeframes for OneCare Service Decisions and Notifications

V. REFERENCE(S)

A. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Dual Eligible Special Needs Plans (D-SNPs)
C. Medicare Managed Care Manual "Benefits and Beneficiary Protections", Section 20.3 Section 20.4 and Section 20.5.2
D. Department of Health Care Services (DHCS) Letter of July 20, 2020: Post-Stabilization Authorization Payment Disputes
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Health, Health Network Service Agreement
G. CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification
H. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
I. CalOptima Health Policy DD.2005: Member-Informing Materials Requirements
J. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
K. CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities

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L. CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network
M. CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities
N. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
O. CalOptima Health Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model
P. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers
Q. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
R. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
S. CalOptima Health Policy HH.2002: Sanctions
T. CalOptima Health Policy HH.2005: Corrective Action Plan
U. CalOptima Health Utilization Management Program
V. Department of Health Care Services All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates (Revised 08/31/2022)
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-002: Alternative Format Selection for Members with Visual Impairments
X. Department of Health Care Services All Plan Letter (APL) 22-006: Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 17-018)
Y. Department of Health Care Services (DHCS) All- Plan Letter (APL) 22-010: Cancer Biomarker Testing
Z. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-009: Post Stabilization Care Services
AA. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-003: Abortion Services (Supersedes APL 22-022)
BB. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
CC. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-019: Consent to Outpatient Mental Health Treatment or Counseling
DD. California Welfare and Institutions Code, §§14103.6 and 14185(a)(1)
EE. Health and Safety Code, Sections 1363.5 and 1367.01
FF. Family Code, Section 6924
GG. Medi-Cal Member Handbook
HH. OneCare Evidence of Coverage
II. Title 28, California Code of Regulations (CCR), §1300.71.4
JJ. Title 42, Code of Federal Regulations (CFR), §§ 422.113 (b)(2)(ii), (b)(3) and (c), 422.138(a) and (b)(1-3), 422.562 (a)(4), 422.566 (a)(d), 422.590 (h), 422.629 (k)(3) and (4), 423.562(a)(5), 423.566 (a)(d), 423.590 (f), 438.114 (a), 438.404(a) and (c)(5), and 438.910(d)
KK. National Committee for Quality Assurance (NCQA) HP Standards and Guidelines, MED 9 Element D, Factor 3

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/02/2009	Department of Health Care Services (DHCS)	Approved as Submitted
02/24/2013	Department of Health Care Services (DHCS)	Approved as Submitted
07/11/2014	Department of Health Care Services (DHCS)	Approved as Submitted
08/17/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/26/2018	Department of Health Care Services (DHCS)	Approved as Submitted
04/19/2021	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

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Date	Regulatory Agency	Response
08/17/2022	Department of Health Care Services (DHCS)	File and Use
09/27/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
02/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
02/22/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/19/2023	Department of Health Care Services (DHCS)	File and Use
09/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/07/2024	Department of Health Care Services (DHCS)	File and Use
10/17/2024	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
05/08/2025	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/03/2021	Regular Meeting of the CalOptima Board of Directors
08/07/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	01/01/1998	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	05/01/1999	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	07/01/2000	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2003	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	10/01/2003	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	06/01/2007	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	01/01/2009	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	08/01/2009	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	09/01/2011	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	02/01/2012	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	11/01/2012	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	09/01/2013	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2014	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2015	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	08/01/2015	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Correction	05/10/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	06/01/2017	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	12/01/2017	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
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Revised	08/01/2022	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	09/01/2022	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	01/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	05/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	07/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	08/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
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Revised	02/01/2024	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	05/01/2024	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	11/01/2024	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	04/01/2025	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	06/01/2025	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	07/01/2025	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Authorized Representative	For purposes of this policy, an individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423 (Subpart M), Part 422 (Subpart M), or Part 438 (Subpart F), as applicable, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the appeals process.
Authorization Request Form (ARF)	CalOptima Health's form to request authorization for Covered Services
Autism Spectrum Disorder (ASD)	A developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS) and Asperger syndrome.
Behavioral Health Care	Evaluation and treatment of psychological and substance abuse disorders. Specialty mental health services may include, but are not limited to, medication support services, day treatment intensive services, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facilities services.
Biomarker Test	A diagnostic test, single or multigene, of an individual's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide treatment. Biomarkers, also called tumor markers, are substances found in higher-than-normal levels in the cancer itself, or in blood, urine, or tissues of some individuals with cancer. Biomarkers can determine the likelihood some types of cancer will spread. They can also help doctors choose the best treatment. For some cancers, certain tumor markers may be more helpful for staging than treatment planning.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
California Children's Services (CCS)-Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Health Direct	A direct health care program operated by that includes both COHD-Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.

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Term	Definition
Comprehensive Diagnostic Evaluation	A developmental screening that can be used to determine a diagnosis of autism spectrum disorder. It may also be able to identify other member needs if a diagnosis of ASD is not found.
Concurrent Review	A review of Medical Necessity of an authorization request for the Member's treatment regimen that is already in place while the Member is currently in an acute or post-acute setting, or in an ongoing course of care in an outpatient or community setting.
Continuity of Care	Medi-Cal: Services provided to a Member rendered by an Out-of-Network Provider with whom the Member has a pre-existing provider relationship. OneCare: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; and 5. Appropriate discharge planning; and Timely placement at different levels of care including hospital, skilled nursing, and home health care.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as

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Term	Definition
	specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.

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Term	Definition
Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services, and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.
Emergency Medical Condition	Medi-Cal: A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: 1. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2. Serious impairment to bodily function; and/or 3. Serious dysfunction of any bodily organ or part. OneCare: A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	Medi-Cal: Covered inpatient and outpatient services that are furnished by a Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition. OneCare: Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Initial Emergency Encounter	A Member's presentation to the emergency department for outpatient Emergency Services or the Member's inpatient emergency admission, whichever occurs first.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic

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Term	Definition
	Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	A beneficiary enrolled in a CalOptima Health program.
Minor Consent Services	Those Covered Services of a sensitive nature which minors do not need parental consent to access, including but not limited to the following situations: 1. Sexual assault, including rape; 2. Drug or alcohol abuse for minors 12 years of age or older; 3. Pregnancy; 4. Family planning; 5. Sexually transmitted diseases (STDs) in minors 12 years of age or older; 6. Diagnosis or treatment of infectious, contagious, or communicable diseases in minors 12 years of age or older if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer; and 7. Outpatient mental health care for minors 12 years of age or older who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924 and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the minors are the alleged victims of incest or Child abuse.
Non-Contracted Provider	Medi-Cal: A Provider that is not obligated by written contract to provide Covered Services to a Member. OneCare: A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Non-Specialty Mental Health Services (NSMHS)	Mild-to-moderate mental health coverage requirements of CalOptima for Medi-Cal Members that are delivered via managed care and include the following: 1. Mental health evaluation and treatment, including individual, group and family psychotherapy 2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition

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Term	Definition
	3. Outpatient services for purposes of monitoring drug therapy 4. Psychiatric consultation 5. Outpatient laboratory, drugs, supplies and supplements
Organization Determination	Any decision made by an entity regarding receipt of, or payment for, a managed care item or service, the amount that the entity requires a member to pay for an item or service, or a limit on the quantity of items or service.
Out-of-Area	Outside of the Service Area
Out-of-Network	Health Network: Outside of the selected Health Network's participating provider network within the Service Area Provider [CalOptima Health]: A Provider that does not participate in CalOptima Health's Network.
Post-Stabilization Care Services	Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized to maintain the stabilized condition, in accordance with 42 CFR section 31 438.114 and 28 CCR section 1300.71.4 to improve or resolve the Member's condition.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	Medi-Cal: A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Professional Person	A person authorized to provide services under Family Code § 6924, including registered psychologists, psychology trainees, associate clinical social workers, social work interns, and psychiatrists.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Prudent Layperson	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.

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Term	Definition
Qualified Licensed Physician	For purposes of this policy, if CalOptima Health or a Health Network expects to issue a partially or fully adverse medical necessity decision based on the initial review of the request, the request shall be reviewed by a qualified licensed physician with a current and unrestricted license to practice in California or other appropriate health professional with expertise in the field of medicine or health care that is appropriate for the services at issue, including knowledge of Medicare and Medi-Cal coverage criteria, before issuing the Coverage Decision Letter (OD) or Notice of Action (NOA).
Referral	The process of a Provider directing a Member to another Provider for care and /or services. A referral may or may not need to be authorized and the Member may be redirected to another Provider from the original requested Provider.
Retrospective Review	A form of medical records review that is conducted after the Member's discharge to track appropriateness of care and consumption of resources.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.
Specialist Physician	A physician who has obtained additional education/training in a focused clinical area and does not function as a PCP.
Tertiary Care	Specialized consultative care provided by specialists working in a center with personnel and facilities experienced in handling complex, uncommon or highly complicated diagnostics and treatments, such as organ transplants. Tertiary Care is provided upon Referral from primary or secondary medical personnel and is a level of care that is not available in a community setting.
Urgent Authorization Request	An authorization request required to be addressed within seventy-two (72) hours, as a normal timeframe for authorization will be detrimental to a Member's life or health, and jeopardizes the Member's ability to regain maximum function, or result in loss of life, limb, or other majorly body function.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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Policy:	GG.1508
Title:	**Authorization and Processing of Referrals**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/*
Effective Date:	01/01/1996
Revised Date:	07/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☐ PACE

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I. PURPOSE

This policy establishes the procedure by which CalOptima Health and its Health Networks shall process a request for Prior Authorization, Concurrent Review, and Retrospective Review of Covered Services for a Member.

II. POLICY

A. CalOptima Health and its Health Networks shall process requests for Prior Authorization, Concurrent Review, and Retrospective Review within the timeframes specified in this Policy. CalOptima Health and its Health Networks shall maintain appropriate communication with the Member, the Member's Authorized Representative, and Practitioner or Provider, throughout the Prior Authorization process to facilitate delivery of appropriate services.

B. For Members enrolled in OneCare, CalOptima Health and its Health Networks shall ensure the authorization process for Covered Services is consistently applied.

1. Confirm the process of diagnoses or other medical criteria that are in the basis for coverage determinations for the specific item or service;

2. Basic benefits item or service is Medically Necessary; or

3. Supplemental benefits service or benefit is clinically appropriate.

C. For Members enrolled in OneCare, CalOptima Health or a Health Network, as applicable, shall accept an Organization Determination request from a Member or Member's Authorized Representative and shall not redirect the Member or Member's Authorized Representative to the Provider office to make such request.

1. If a OneCare Health Network Member calls CalOptima Health before contacting the Health Network regarding an authorization, CalOptima Health shall transfer such calls to the appropriate Health Network Customer Service line for assistance.

D. CalOptima Health and its Health Networks shall follow the applicable Timeframes for Decisions and Notifications Table, as set forth in Attachments A and B of this Policy, for all requested

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services, whether in- or out-of-network, as well as CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

E. CalOptima Health and its Health Networks shall ensure that clinical decision made related to coverage or denial of requested services due in whole or in part to Medical Necessity are consistent and based upon sound medical evidence, in accordance with CalOptima Health Policies GG.1535: Utilization Review Criteria and Guidelines, and GG.1541: Utilization Management Delegation.

F. With respect to the Whole Child Model (WCM) program, CalOptima Health and its Health Networks shall ensure compliance with applicable statutory, regulatory, and contractual requirements, as well as California Department of Health Care Services (DHCS) guidance, including, but not limited to, All Plan Letter (APL) 21-005: California Children's Services Whole Child Model Program, or any superseding APL. Without limiting the foregoing, CalOptima Health and the Health Networks shall:

1. Use all current and applicable California Children's Services (CCS) Program guidelines, including CCS Program regulations, CCS Program information notices, and CCS Numbered Letters in developing criteria for use by their respective medical director or the equivalent, and other care management staff.

2. Use evidenced-based guidelines or treatment protocols that are medically appropriate given the Member's CCS-Eligible Condition in cases in which applicable CCS clinical guidelines do not exist.

G. CalOptima Health and its Health Networks shall ensure the authorization process for Covered Services is consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.

H. CalOptima Health and its Health Networks must notify network providers of all services that require prior authorization, concurrent authorization or retrospective authorization.

I. CalOptima Health and the Health Networks shall make utilization management (UM) decisions based only on appropriateness of care and service, and existence of coverage. CalOptima Health and the Health Networks do not reward Practitioners or other individuals for issuing denial for coverage, care, or services. CalOptima Health and the Health Networks do not provide financial incentives to utilization management decision-makers to encourage decisions that result in underutilization.

J. CalOptima Health and the Health Networks shall not require a Provider or Practitioner to request Prior Authorization for Covered Services specified in Section III.A. of this Policy.

K. For services that do not require a Prior Authorization, Providers, including Specialist Physicians, shall refer the Member to a contracted Provider, unless such Provider is unavailable in-network. Referrals to an out-of-network Provider shall be processed in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

1. For Sensitive Services, Members may access any Provider, including those who are out-of-network, as outlined in CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network and in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 24-003: Abortion Services.

2. For Health Network Members, a Provider, including a Specialist Physician, shall follow the Health Network's authorization process.

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L. A Provider or Practitioner may request a retrospective authorization review for Covered Services rendered to a Member when extenuating circumstances prevent the Provider or Practitioner's ability to obtain a Prior Authorization request and when one (1) of the following conditions apply:

1. The Member has Other Health Coverage (OHC);

2. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal or OneCare, as applicable and CalOptima Health eligibility at the time of service; or

3. The Member's Medical condition requires additional, immediate medical need during a planned procedure.

4. Retrospective submission timeframe:

   a. For a OneCare Member as long as such a request is made within sixty (60) calendar days after the initial date of service.

   b. For a Medi-Cal Member as long as such a request is made within a reasonable established time limit, not to exceed sixty (60) calendar days from the date of service.

M. CalOptima Health and a Health Network shall ensure that all contracted Providers and non-contracting Specialist Physicians and Providers are informed of the Prior Authorization and Referral process at the time of Referral.

N. CalOptima Health and its Health Networks that are responsible for utilization management of hospital services shall have a plan health professional or a contracting, qualified, and licensed physician available twenty-four (24) hours a day, seven (7) days a week to authorize Medically Necessary Post-Stabilization Care Services, to coordinate the transfer of stabilized Members in an emergency department if necessary, and for general communication with emergency room personnel.

O. CalOptima Health and its Health Networks shall provide coverage and payment, for hospital Emergency Services and Post Stabilization Care Services necessary to determine the presence or absence of an Emergency Medical Condition, and if an Emergency Medical Condition exists, for all services Medically Necessary to stabilize the Member's condition regardless of whether or not the request is from a contracted Provider, Non-Contracted Provider or Out-of- Network, as specified in Section III.D, E, and G of this Policy.

P. If a Member exhausts his or her Medicare benefits as provided under the OneCare Program, and at the request of the Health Network under a shared risk contract, CalOptima Health shall authorize Covered Services in accordance with this Policy or other applicable CalOptima Health policies and procedures.

Q. CalOptima Health and its Health Networks shall maintain a system for tracking and monitoring all Referrals for Provider and Member-requested (OneCare Members only) health care services and supplies requiring Prior Authorization as follows:

1. Referral turnaround time for issuing a determination;

2. Criteria used in making the determination;

3. If denied, deferred, or modified, a copy of the Notice of Action (NOA); and

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4. Specific services and supplies approved, denied, deferred, or modified, including classifying non-medical necessity denials.

III. PROCEDURE

A. Services Excluded from the Prior Authorization Process

1. For the Medi-Cal and OneCare programs, the following services do not require Prior Authorization:

   a. Emergency Services or emergency care

      i. CalOptima Health and its Health Networks shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

      ii. CalOptima Health and its Health Networks shall follow the standard definition of a Prudent Layperson, acting reasonably, to determine that the presenting complaint might be an emergency.

      iii. The attending emergency physician, or the Provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on such Member's assigned Health Network or on CalOptima Health if such Member is a CalOptima Health Direct Member, whichever is applicable.

   b. Preventive and primary care services, including recommended routine immunizations;

   c. Basic prenatal care;

   d. Family Planning Services:

      i. Health education and counseling necessary to make informed choices and to understand contraceptive methods;

      ii. Limited history and physical examination for family planning services;

      iii. Laboratory tests, if medically indicated, as part of the decision-making process for selecting a method of contraception;

      iv. Diagnosis and treatment of sexually transmitted diseases (STDs), if medically indicated, during one (1) visit;

      v. Screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and Referral for treatment;

      vi. Provision of contraceptive pills, devices, and supplies;

      vii. Follow-up care for complications associated with contraceptive methods issued by a family planning Provider or Practitioner;

      viii. Tubal ligation;

      ix. Vasectomies; and

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x. Pregnancy testing and counseling.

e. Routine obstetrical services; and

f. Elective abortions. *Non-emergency inpatient hospitalization for the performance of an abortion may require prior authorization.

i. CalOptima Health shall cover abortion services, as well as the medical services and supplies incidental or preliminary to an abortion.

ii. CalOptima Health shall not impose annual or lifetime limits on the coverage of outpatient abortion services.

g. Cancer Biomarker testing services for a Member who meets the following criteria, in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 22-010: Cancer Biomarker Testing:

i. Advanced or metastatic stage three (3) or four (4) cancer; or

ii. Cancer progression or recurrence in the Member with advanced or metastatic stage three (3) or stage four (4) cancer.

iii. For the CalOptima Health Direct and CalOptima Health Community Network programs, a Provider or Practitioner shall submit:

a) For portal authorizations, when biomarker testing is requested, the Provider will attest to the Member having stage three (3) or stage four (4) cancer and the request will be processed.

b) For fax authorizations where biomarker testing is requested, the Provider will attest to the stage three (3) and stage four (4) cancer diagnosis on the Authorization Request Form (ARF).

2. For the OneCare program, in addition to the services identified in Section III.A.1. of this Policy, the following services do not require Prior Authorization:

a. Services for Emergency Medical Conditions, including emergency Behavioral Health Care;

b. Urgent Care sought outside of the service area of Orange County, California;

c. Urgent Care under unusual and extraordinary circumstances provided in the service area of Orange County, California when the contracted medical provider is unavailable or inaccessible; and

d. Out-of-area renal dialysis services.

3. For the Medi-Cal Program, in addition to the services identified in Section III.A.1. of this policy, the following services do not require Prior Authorization:

a. Minor Consent Services: The following Minor Consent Services provided to a CalOptima Health Medi-Cal Member less than twenty-one (21) years of age do not require parental consent or Prior Authorization. Minor Consent Services are Covered Services of a sensitive nature related to:

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i. Sexual assault, including rape;

ii. Drug or alcohol abuse for a Member twelve (12) years of age or older;

iii. Pregnancy;

iv. Family Planning, including termination of pregnancy *Non-emergency inpatient hospitalization for the performance of an abortion may require prior authorization;

v. Sexually transmitted diseases (STDs) or HIV/AIDS for a Member twelve (12) years of age or older; and

vi. Non-Specialty Mental Health Services (NSMHS) for children ages twelve (12) and over who are deemed mature enough by the attending Professional Person to participate intelligently in their health car pursuant to Family Code Section 6924.

b. Initial mental health assessments; and

c. The Comprehensive Diagnostic Evaluation for assessment of Autism Spectrum Disorder.

B. Responsibilities of Primary Care Provider (PCP) and Specialist Physician

1. A PCP is required to maintain twenty-four (24) hour access for the Member, including availability for response to emergency and urgent questions from the Member in accordance with CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities. When possible, the PCP shall evaluate and counsel the Member and direct the Member to the most appropriate level of service based on the Member's condition.

2. All services shall be provided in the manner and time frames set forth in CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities.

3. Member Eligibility Verification

a. A Provider or Practitioner shall request basic information from a Member when providing services, including access to the Member's Medi-Cal Beneficiary Identification Card (BIC), Medicare identification card, or CalOptima Health identification card, or shall perform an eligibility verification using CalOptima Health's Provider Portal at www.caloptima.org.

b. Prior Authorization does not guarantee eligibility at the time services are rendered.

c. For Medi-Cal Members, a Provider or Practitioner shall verify eligibility at the time the services are provided, in accordance with CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification.

C. Authorization Requests

1. For a CalOptima Health Direct Member, a Practitioner or Provider shall request the following authorizations in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers:

a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.

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b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.

c. Request for Retrospective Review subject to the limitations described in Section II.L. of this Policy.

2. For a Health Network Member, a Practitioner or Provider shall request the following authorizations in accordance with the Health Network's authorization policy:

a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.

b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.

c. Request for Retrospective Review subject to the limitations described in Section II.L. of this policy.

3. An Urgent Authorization Request may be submitted if a routine authorization timeframe will be detrimental to a Member's life or health, jeopardize the Member's ability to regain maximum function, or may result in loss of life, limb, or other major body function. Such request is required to be decided within seventy-two (72) hours or as soon as the Member's health condition requires.

4. A hospital must submit the request for Prior Authorization and obtain approval from CalOptima Health or a Health Network, as applicable, for scheduled inpatient procedures prior to a Member's admission to inpatient status.

5. All CalOptima Health and Health Network authorization requests must include clinical records that validate the need for the requested item or service.

D. Hospital Notification of Emergency Services

1. A hospital shall notify CalOptima Health or the Member's Health Network, as applicable, within twenty-four (24) hours of a Member's Initial Emergency Encounter. Until a notification system is implemented, a hospital shall use best efforts to provide such notice within twenty-four (24) hours of the Member's presentation to the emergency department for outpatient Emergency Services.

2. If the Initial Emergency Encounter occurs on a holiday or weekend, notification to CalOptima Health or the Member's Health Network shall be made the following business day, or the time Member identity is known, or would have been known with the exercise of reasonable diligence.

E. Prior Authorization Request (Post-Stabilization Care Services)

1. Medically Necessary Post-Stabilization Care Services from Contracted Providers and Non-Contracted Providers

a. A hospital must request a Prior Authorization for Post-Stabilization Care Services when a Member who has received Emergency Services for an Emergency Medical Condition is determined to have reached medical stability, but requires additional, Medically Necessary inpatient Covered Services that are:

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i. Related to the Emergency Medical Condition; and

ii. Provided to maintain, improve, or resolve the Member's stabilized medical condition.

b. All requests and responses to a Post Stabilization Care Service request are required to be fully documented. Documentation shall include but is not limited to;

i. The date and time of the request;

ii. The name of the health care Provider making the request; and

iii. The name of the CalOptima Health or Health Network staff responding to the request.

c. A Prior Authorization request for Medically Necessary Post-Stabilization Care Services shall consist of a phone call from the facility to CalOptima Health or a Health Network's Utilization Management Department clinician and include the following information to provide sufficient information to make a decision regarding care within thirty (30) minutes for Medi-Cal and sixty (60) minutes for OneCare:

i. Identifying information including Member name, birthdate, CIN, and gender;

ii. Name and role of facility clinician requesting prior authorization, their direct phone number and the name of facility;

iii. Nature of the emergency condition that has been stabilized;

iv. Medical documentation to include at a minimum:

a) History and physical;

b) Vital signs; and

c) Laboratory and/or radiology results.

v. Co-morbid conditions; and

vi. Medical reason for admission to the hospital including proposed treatment.

d. For a CalOptima Health Direct Member enrolled in the Medi-Cal program, CalOptima Health shall process a Prior Authorization request for Medically Necessary Post-Stabilization Care Services in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers.

e. For a Health Network Member enrolled in the Medi-Cal program, the Health Network shall approve or deny a Provider's Prior Authorization request for Post-Stabilization Care Services within thirty (30) minutes after receipt of request that fully complies with Section III.E.1.a-c of this Policy. If the Health Network fails to approve or deny such request within thirty (30) minutes, Medically Necessary Post-Stabilization Care Services are deemed approved.

i Notwithstanding Section III.E.1.d. of this Policy, pursuant to Section 1300.71.4 of Title 28 of the California Code of Regulations, the Health Network may notify the Provider of the denial of such request prior to the commencement of the delivery or during the

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continuation of the delivery of Post-Stabilization Care Services, provided that the disruption of such services (taking into account the time necessary to effect the Member's transfer or discharge) does not have an adverse impact on the efficacy of such services or the Member's medical condition.

ii In the case where the Health Network denies such request and informs the Provider of its decision to transfer the Member to another Provider, the Health Network shall effectuate the transfer of the Member as soon as possible.

f. For a Health Network Member enrolled in the OneCare program, a Health Network shall approve or deny a Provider's Prior Authorization request for Post-Stabilization Care Services within sixty (60) minutes after receipt of request that fully complies with Section III.E.1a-c of this Policy. If the Health Network does not respond to such request within sixty (60) minutes, Medically Necessary Post-Stabilization Care Services are considered approved.

g. CalOptima Health and its Health Networks are also financially responsible for Post-Stabilization Care Services in the event that CalOptima Health or the Health Network:

i. Did not respond to a request for pre-approval within the timeframe allotted (Medi-Cal within thirty (30) minutes, OneCare within sixty (60) minutes);

ii. Could not be contacted; or

iii. Could not reach an agreement with the treating Provider concerning the Member's care and CalOptima Health or the Health Network physician was not available for consultation.

h. In the case where CalOptima Health or a Health Network and the treating Provider cannot reach an agreement concerning the Member's care and the CalOptima Health or Health Network physician is not available for consultation, CalOptima Health or the Health Network shall give the treating Provider the opportunity to consult with a CalOptima Health or Health Network physician and the treating Provider may continue with care of the Member until a CalOptima Health or the Health Network physician is reached or one (1) of the following criteria is met:

i. CalOptima or the Health Network physician with privileges at the treating Provider's hospital assumes responsibility for the Member's care;

ii. CalOptima Health or the Health Network physician assumes responsibility for the Member's care through transfer;

iii. CalOptima Health or the Health Network and the treating Provider reach an agreement concerning the Member's care; or

iv. The Member is discharged.

2. Medically Necessary Non-Urgent Care Following Emergency Room Exam

a. For a CalOptima Health Direct Member enrolled in the Medi-Cal program, CalOptima Health shall process a Prior Authorization request from a non-contracted Provider for Medically Necessary non-urgent care following an exam in the emergency room in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers.

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b. For a Health Network Member enrolled in the Medi-Cal program, a Health Network shall approve or deny a Prior Authorization request for non-urgent care following an exam in the emergency room within thirty (30) minutes after receipt of such request from a non-contracted Provider on behalf of a Member, who has received Emergency Services. If the Health Network does not respond to such request within the required timeframe, Medically Necessary non-urgent care is deemed approved.

3. Health Network staff shall assist the hospital with timely Discharge Planning to facilitate transition to the most appropriate level of care following facility discharge in accordance with the Health Network's policy.

F. Second Medical Opinions

1. A Member or the Member's Authorized Representative has the right to request a second opinion.

2. For Medi-Cal, a Member or the Member's Authorized Representative may request a second opinion from their Practitioner, or by contacting CalOptima Health's Customer Service Department (714-246-8500 or toll-free at 888-587-8088/TDD/TTY: 711), or the Member's Health Network.

3. For OneCare, a Member or the Member's Authorized Representative may request a second opinion from their Practitioner, or by contacting CalOptima Health's OneCare Customer Service Department (714-246-8711 or toll-free at 877-412-2734/TDD/TTY: 711), or the Member's Health Network.

4. CalOptima Health or a Health Network requires Prior Authorization for a second opinion by a Specialist Physician.

5. A Member may receive a second opinion from an in-network Provider at no cost. If an in-network Provider is not available, CalOptima Health or their Health Network shall make arrangements for the Member to obtain a second opinion from an out-of-network Provider at no cost.

6. A Member may receive a third opinion, at no cost to a Member, if there is a disparity between the initial and second opinion.

G. Out-of-Network Services

1. CalOptima Health or a Health Network shall provide Medically Necessary and Covered Services to a Member through an out-of-network Provider when CalOptima Health or the Health Network is unable to provide services within the network, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

2. CalOptima Health or a Health Network shall adequately and timely cover out-of-network services, for as long as CalOptima Health or the Health Network is unable to provide the services within the network. CalOptima Health or the Health Network shall process out-of-network service requests, as specified in the Timeframes for Decisions and Notifications Tables.

3. All requests requiring Prior Authorization shall require the requestor to submit a fully completed Authorization Request Form to CalOptima Health along with medical justification sufficient to make a determination and the physician signature. CalOptima Health shall process the request, as specified in the Timeframes for Decisions and Notifications Tables.

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4. CalOptima Health or a Health Network shall follow the Timeframes for Decisions and Notifications Tables for all requested services, whether in or out of the network.

5. CalOptima Health or a Health Network shall arrange for a Letter of Agreement (LOA) with an identified out-of-network Provider, in accordance with CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts.

6. CalOptima Health or a Health Network shall provide continued access as follows:

   a. For newly enrolled Medi-Cal beneficiaries, for up to twelve (12) months, to an out-of-network Provider with whom the Member has had an ongoing relationship if there are no quality-of-care issues with the Provider and the Provider accepts contracted or Medi-Cal rates in accordance with CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services.

   b. For Members eligible with the California Children's Services (CCS) Program and transitioned into the WCM program, for up to twelve (12) months, to an out-of-network CCS-paneled Provider, specialized or customized durable medical equipment provider, currently prescribed medication, and public health nurse, in accordance with CalOptima Health Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services, and GG.1330: Case Management – California Children's Services Program/Whole Child Model.

H. Denials, Deferrals, Dismissals, Terminations and Modifications of Prior Authorization Requests

1. In-Network Specialist Physician. CalOptima Health or a Health Network may redirect specialty care Prior Authorization requests to an in-network Specialist Physician under the following conditions:

   a. All modification, denial, dismissal, termination and notification requirements are followed pursuant to regulation requirements; and

   b. The in-network Specialist Physician is selected based on the following:

      i. A demonstrated ability to provide the services requested;

      ii. Prolific experience providing the services requested;

      iii. Volume of the requested care previously provided;

      iv. An existing relationship with CalOptima Health or the Health Network, as applicable;

      v. A proven ability to maintain adequate Member access;

      vi. A proven ability to provide care coordination;

      vii. No existing issues related to continuity of care or Tertiary service needs; and

      viii. For Members eligible with the CCS Program and transitioned into the WCM program, a CCS-paneled provider qualified to treat the CCS-Eligible Condition of the CCS child or youth, in accordance with CCS Program rules and regulations.

2. Consultation with Board-Certified Specialist.

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a. CalOptima Health may consult with a Board-Certified specialist if the Prior Authorization request is out of the scope of practice of the physician reviewer.

i. A CalOptima Health Medical Director shall forward a request for review by a Board-Certified specialist to the Prior Authorization manager or Designee for appropriateness;

ii. The Prior Authorization manager or Designee shall forward the request to a contracted external review agency electronically for review; and

iii. Upon receipt of the recommendation of the external review agency, the CalOptima Health Medical Director shall conduct the final review and determination.

b. The UMC shall maintain a list of Board-Certified specialists and will be reviewed annually by the Quality Improvement Committee (QIC).

3. Tertiary Care

a. CalOptima Health or a Health Network shall authorize Tertiary Care Services when a Member requires testing or treatment that is otherwise not available at a non-Tertiary level of care.

b. CalOptima Health shall only authorize Tertiary Care services under the following circumstances:

i. A Member requires testing or treatment that is otherwise not available at a non-Tertiary level of care;

ii. A Member requires interdisciplinary or simultaneous treatments with multiple specialty services as part of a complex, coordinated plan of care;

iii. A Member requires testing or treatment that is otherwise too high of a risk or otherwise not safe to perform at a non-Tertiary level of care;

iv. A Member or Provider requires a referral for experimental or investigational procedures not available in-network and may do so directly through CalOptima Health; and

v. There is no quality-of-care issues for the Provider.

4. Utilization Management (UM) Decision. CalOptima Health and its Health Networks shall ensure the following:

a. Requested health care services may be approved by UM staff who are not qualified health care professionals only when:

i. The UM staff is under the supervision of an appropriately licensed health professional;

ii. There are explicit UM criteria; and

iii. No clinical judgement is required.

b. Requested health care services which require the use of clinical judgement shall be approved by licensed health care professionals.

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c. Decisions to deny or to authorize an amount, duration, or scope less than the requested health care services shall be made by a qualified medical director with a current and unrestricted license to practice in California or other health care professional with appropriate clinical expertise in treating the condition and disease, including knowledge of Medicare and Medi-Cal coverage criteria.

i. Only a qualified, licensed physician or other qualified health care professional, as appropriate, shall deny or authorize an amount, duration, or scope less than the requested health care services based in whole or in part on Medical Necessity for any non-behavioral healthcare services.

ii. Only a qualified, licensed physician or appropriate behavioral healthcare practitioner as appropriate shall review and issue denials for Behavioral Health Care services for Medical Necessity or benefit coverage related to a Medi-Cal Member's behavioral health benefits; and

iii. Only a qualified, licensed physician or qualified, licensed clinical pharmacist shall review and approve, defer, modify or deny prior authorizations for pharmaceutical services.

d. Only qualified, licensed health care professionals supervise review decisions requiring Prior Authorization, including service reductions, and a qualified, licensed physician shall review all denials of a request for health care services based in whole or in part on Medical Necessity.

5. Notification of UM Decision

a. CalOptima Health and its Health Networks shall notify the requesting Practitioner or Provider and/or Member or Member's Authorized Representative, as appropriate, regarding any decision to deny, approve, modify, or delay an authorization request in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. In addition, for OneCare, CalOptima Health and its Health Networks shall ensure compliance with the notification requirements set forth in CalOptima Health Policy MA.6042: Integrated Organization Determinations.

b. If Medical Necessity criteria are not met, and review by a CalOptima Health or Health Network qualified licensed physician does not find the Member requires the requested inpatient level of care and Prior Authorization request is denied, delayed, modified, or alternative treatment is recommended, CalOptima Health or a Health Network shall notify the Member, the Member's Authorized Representative, and the Practitioner or Provider of the reason for the action.

i. CalOptima Health or the Health Network must provide auxiliary aids and services to a family member, friend, or associate of a Member if required by the ADA, including if the individual is identified as the Members' Authorized Representative, or is someone with whom it is appropriate for CalOptima Health or the Health Network to communicate.

ii. Communication needs of must be accommodated for all qualified Members with disabilities, including Authorized Representatives, and be prepared to facilitate alternate format requests for Braille, audio format, large print (no less than 20 point Arial font), and acceptable electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate, in accordance with CalOptima Health PolicyDD.2002: Cultural and Linguistic Services.

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c. For routine (non-urgent) authorization requests, if CalOptima Health or a Health Network does not take action by approving, denying, deferring, or modifying services, on a written request for Prior Authorization of Covered Services within fourteen (14) calendar days after receipt, such request shall be deemed denied by default and a notification of denial for the requested service shall be sent to the Provider and Member in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

I. Availability of CalOptima Health UM Staff and Services

1. CalOptima Health's UM Department shall provide Members or potential Members access to information about the UM process, and the process for authorizing care, in the Medi-Cal Member Handbook, and OneCare Evidence of Coverage available in-print and on the CalOptima Health website at www.caloptima.org.

2. CalOptima Health's UM Department shall provide Practitioners access to information about the UM process, and the process for authorizing care, in the Provider Manual, available on the CalOptima Health website at www.caloptima.org.

3. UM staff shall be available for inbound calls including toll free and collect calls, regarding UM issues during CalOptima Health normal business hours, Monday – Friday, from 8 a.m. to 5 p.m., with the exception of holidays. All inbound calls will be received by CalOptima Health's Customer Service Department and routed to appropriate UM staff.

   a. UM staff shall provide a toll-free number (and accept collect calls regarding UM issues.

   b. UM staff shall identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues.

   c. UM staff shall send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.

   d. UM staff shall be accessible to callers who have questions about the UM process.

   e. UM qualified, licensed physicians shall be available to answer denial determination questions during normal business hours and after hours calls regarding UM issues. During business hours, calls shall be directed to the UM Department and transferred to the appropriate UM physician. The after-hours answering service shall direct calls to the on-call physician.

   f. A UM physician shall respond to a treating Provider request within thirty (30) minutes for an emergency call and within one (1) business day for all other requests.

4. UM staff shall be available to receive inbound communication regarding UM issues after normal business hours through the on-call-service, facsimile, electronic, and telephone communications (e.g., sending e-mail messages or leaving voicemail messages). Communications received after normal business hours are returned on the next business day. Communications received after midnight on Monday-Friday are responded to on the same business day.

5. CalOptima Health shall utilize a telecommunications device for the deaf/telephone typewriter, or teletypewriter (TDD/TTY) services for deaf, hard of hearing or speech impaired, or comparable device or service available to assist Members, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic and Services (CalOptima Health is able to

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receive and send TDD/TYY messages and has a separate phone number for receiving TDD/TYY messages.).

6. CalOptima Health shall provide language assistance services free of charge to Members. CalOptima Health shall provide services in the requested language through bilingual staff or an interpreter, to assist Members with UM issues, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

7. CalOptima Health shall send a CalOptima Health Medi-Cal Member Handbook/Evidence of Coverage (EOC) booklet as part of the enrollment packet, as specified in CalOptima Health Policy DD.2005: Member-Informing Materials Requirements. The handbook will note the availability of UM staff in regard to UM issues and will include the Customer Service Department phone number and the TDD/TTY phone number.

8. Annually, CalOptima Health shall inform Medi-Cal Members of the availability of the CalOptima Health Member Handbook/Evidence of Coverage.

9. Annually, CalOptima Health shall send via U.S. Mail the OneCare Evidence of Coverage, for OneCare Members.

J. Failure of a Health Network or CalOptima Health department to comply with CalOptima Health's authorization policies and procedures, as applicable, as well as relevant statutory, regulatory, and/or contractual requirements, shall lead to disciplinary action which may include, but not be limited to, education and training on CalOptima Health's authorization process and reports to the Utilization Management Committee (UMC), Delegation Oversight Committee (DOC), and/or the Compliance Committee.

1. Continued non-compliance may lead to the issuance of a Corrective Action Plan (CAP) and/or Sanctions, in accordance with CalOptima Health Policies HH.2002: Sanctions and HH.2005: Corrective Action Plan.

IV. ATTACHMENT(S)

A. Timeframes for Medi-Cal Service Decisions and Notifications
B. Timeframes for OneCare Service Decisions and Notifications

V. REFERENCE(S)

A. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Dual Eligible Special Needs Plans (D-SNPs)
C. Medicare Managed Care Manual "Benefits and Beneficiary Protections", Section 20.3 Section 20.4 and Section 20.5.2
D. Department of Health Care Services (DHCS) Letter of July 20, 2020: Post-Stabilization Authorization Payment Disputes
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Health, Health Network Service Agreement
G. CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification
H. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
I. CalOptima Health Policy DD.2005: Member-Informing Materials Requirements
J. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
K. CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities

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L. CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network
M. CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities
N. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
O. CalOptima Health Policy GG.1330: Case Management – California Children's Services Program/Whole Child Model
P. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers
Q. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
R. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
S. CalOptima Health Policy HH.2002: Sanctions
T. CalOptima Health Policy HH.2005: Corrective Action Plan
U. CalOptima Health Utilization Management Program
V. Department of Health Care Services All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates (Revised 08/31/2022)
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-002: Alternative Format Selection for Members with Visual Impairments
X. Department of Health Care Services All Plan Letter (APL) 22-006: Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 17-018)
Y. Department of Health Care Services (DHCS) All- Plan Letter (APL) 22-010: Cancer Biomarker Testing
Z. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-009: Post Stabilization Care Services
AA. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-003: Abortion Services (Supersedes APL 22-022)
BB. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
CC. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-019: Consent to Outpatient Mental Health Treatment or Counseling
DD. California Welfare and Institutions Code, §§14103.6 and 14185(a)(1)
EE. Health and Safety Code, Sections 1363.5 and 1367.01
FF. Family Code, Section 6924
GG. Medi-Cal Member Handbook
HH. OneCare Evidence of Coverage
II. Title 28, California Code of Regulations (CCR), §1300.71.4
JJ. Title 42, Code of Federal Regulations (CFR), §§ 422.113 (b)(2)(ii), (b)(3) and (c), 422.138(a) and (b)(1-3), 422.562 (a)(4), 422.566 (a)(d), 422.590 (h), 422.629 (k)(3) and (4), 423.562(a)(5), 423.566 (a)(d), 423.590 (f), 438.114 (a), 438.404(a) and (c)(5), and 438.910(d)
KK. National Committee for Quality Assurance (NCQA) HP Standards and Guidelines, MED 9 Element D, Factor 3

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/02/2009	Department of Health Care Services (DHCS)	Approved as Submitted
02/24/2013	Department of Health Care Services (DHCS)	Approved as Submitted
07/11/2014	Department of Health Care Services (DHCS)	Approved as Submitted
08/17/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/26/2018	Department of Health Care Services (DHCS)	Approved as Submitted
04/19/2021	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

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Date	Regulatory Agency	Response
08/17/2022	Department of Health Care Services (DHCS)	File and Use
09/27/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
02/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
02/22/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/19/2023	Department of Health Care Services (DHCS)	File and Use
09/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/07/2024	Department of Health Care Services (DHCS)	File and Use
10/17/2024	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
05/08/2025	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/03/2021	Regular Meeting of the CalOptima Board of Directors
08/07/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	01/01/1998	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	05/01/1999	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	07/01/2000	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2003	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	10/01/2003	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	06/01/2007	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	01/01/2009	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	08/01/2009	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	09/01/2011	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	02/01/2012	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	11/01/2012	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	09/01/2013	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2014	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2015	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	08/01/2015	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Correction	05/10/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	06/01/2017	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	12/01/2017	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	03/01/2021	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	06/03/2021	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	08/01/2022	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	09/01/2022	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	01/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	05/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	07/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	08/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	12/31/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	02/01/2024	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	05/01/2024	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	11/01/2024	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	04/01/2025	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	06/01/2025	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	07/01/2025	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare

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IX. GLOSSARY

Term	Definition
Authorized Representative	For purposes of this policy, an individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423 (Subpart M), Part 422 (Subpart M), or Part 438 (Subpart F), as applicable, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the appeals process.
Authorization Request Form (ARF)	CalOptima Health's form to request authorization for Covered Services
Autism Spectrum Disorder (ASD)	A developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS) and Asperger syndrome.
Behavioral Health Care	Evaluation and treatment of psychological and substance abuse disorders. Specialty mental health services may include, but are not limited to, medication support services, day treatment intensive services, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facilities services.
Biomarker Test	A diagnostic test, single or multigene, of an individual's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide treatment. Biomarkers, also called tumor markers, are substances found in higher-than-normal levels in the cancer itself, or in blood, urine, or tissues of some individuals with cancer. Biomarkers can determine the likelihood some types of cancer will spread. They can also help doctors choose the best treatment. For some cancers, certain tumor markers may be more helpful for staging than treatment planning.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
California Children's Services (CCS)-Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Health Direct	A direct health care program operated by that includes both COHD-Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.

For 20250904 BOD Review Only

Term	Definition
Comprehensive Diagnostic Evaluation	A developmental screening that can be used to determine a diagnosis of autism spectrum disorder. It may also be able to identify other member needs if a diagnosis of ASD is not found.
Concurrent Review	A review of Medical Necessity of an authorization request for the Member's treatment regimen that is already in place while the Member is currently in an acute or post-acute setting, or in an ongoing course of care in an outpatient or community setting.
Continuity of Care	Medi-Cal: Services provided to a Member rendered by an Out-of-Network Provider with whom the Member has a pre-existing provider relationship. OneCare: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; and 5. Appropriate discharge planning; and Timely placement at different levels of care including hospital, skilled nursing, and home health care.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as

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Term	Definition
	specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.

For 202500

Term	Definition
Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services, and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.
Emergency Medical Condition	Medi-Cal: A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: 1. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2. Serious impairment to bodily function; and/or 3. Serious dysfunction of any bodily organ or part. OneCare: A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	Medi-Cal: Covered inpatient and outpatient services that are furnished by a Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition. OneCare: Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Initial Emergency Encounter	A Member's presentation to the emergency department for outpatient Emergency Services or the Member's inpatient emergency admission, whichever occurs first.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic

For 20250904 BOD Review Only

Term	Definition
	Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	A beneficiary enrolled in a CalOptima Health program.
Minor Consent Services	Those Covered Services of a sensitive nature which minors do not need parental consent to access, including but not limited to the following situations: 1. Sexual assault, including rape; 2. Drug or alcohol abuse for minors 12 years of age or older; 3. Pregnancy; 4. Family planning; 5. Sexually transmitted diseases (STDs) in minors 12 years of age or older; 6. Diagnosis or treatment of infectious, contagious, or communicable diseases in minors 12 years of age or older if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer; and 7. Outpatient mental health care for minors 12 years of age or older who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924 and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the minors are the alleged victims of incest or Child abuse.
Non-Contracted Provider	Medi-Cal: A Provider that is not obligated by written contract to provide Covered Services to a Member. OneCare: A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Non-Specialty Mental Health Services (NSMHS)	Mild-to-moderate mental health coverage requirements of CalOptima for Medi-Cal Members that are delivered via managed care and include the following: 1. Mental health evaluation and treatment, including individual, group and family psychotherapy 2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition

For 20250904 BOD Preview Only

Term	Definition
	3. Outpatient services for purposes of monitoring drug therapy 4. Psychiatric consultation 5. Outpatient laboratory, drugs, supplies and supplements
Organization Determination	Any decision made by an entity regarding receipt of, or payment for, a managed care item or service, the amount that the entity requires a member to pay for an item or service, or a limit on the quantity of items or service.
Out-of-Area	Outside of the Service Area
Out-of-Network	Health Network: Outside of the selected Health Network's participating provider network within the Service Area Provider [CalOptima Health]: A Provider that does not participate in CalOptima Health's Network.
Post-Stabilization Care Services	Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized to maintain the stabilized condition, in accordance with 42 CFR section 31 438.114 and 28 CCR section 1300.71.4 to improve or resolve the Member's condition.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	Medi-Cal: A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Professional Person	A person authorized to provide services under Family Code § 6924, including registered psychologists, psychology trainees, associate clinical social workers, social work interns, and psychiatrists.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Prudent Layperson	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.

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Term	Definition
Qualified Licensed Physician	For purposes of this policy, if CalOptima Health or a Health Network expects to issue a partially or fully adverse medical necessity decision based on the initial review of the request, the request shall be reviewed by a qualified licensed physician with a current and unrestricted license to practice in California or other appropriate health professional with expertise in the field of medicine or health care that is appropriate for the services at issue, including knowledge of Medicare and Medi-Cal coverage criteria, before issuing the Coverage Decision Letter (OD) or Notice of Action (NOA).
Referral	The process of a Provider directing a Member to another Provider for care and /or services. A referral may or may not need to be authorized and the Member may be redirected to another Provider from the original requested Provider.
Retrospective Review	A form of medical records review that is conducted after the Member's discharge to track appropriateness of care and consumption of resources.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.
Specialist Physician	A physician who has obtained additional education/training in a focused clinical area and does not function as a PCP.
Tertiary Care	Specialized consultative care provided by specialists working in a center with personnel and facilities experienced in handling complex, uncommon or highly complicated diagnostics and treatments, such as organ transplants. Tertiary Care is provided upon Referral from primary or secondary medical personnel and is a level of care that is not available in a community setting.
Urgent Authorization Request	An authorization request required to be addressed within seventy-two (72) hours, as a normal timeframe for authorization will be detrimental to a Member's life or health, and jeopardizes the Member's ability to regain maximum function, or result in loss of life, limb, or other majorly body function.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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For 20250904 BOD Review Only

Attachment A

TIMFRAMES FOR MEDI-CAL SERVICE DECISIONS AND NOTIFICATIONS

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Electronic or Written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Routine (Non-urgent) Pre-Service Prior Authorization/ Prospective or outpatient service requests.	Approve, Modify, or Deny within 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 14 calendar days from the receipt of the request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days.
Routine (Non-urgent) Pre-Service – Extension Needed • Additional clinical information required. • Require consultation by an Expert Reviewer. • Additional examination or tests to be performed.	Approve, Modify, or Deny within 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 14 calendar days from the receipt of the request. • The decision may be delayed/deferred, and the time limit extended an additional 14 calendar days from the Medical Director pend request. Only where the Member or the Member's provider requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. • CalOptima Health will notify the member and practitioner of the decision to delay/defer, in writing, within 14 calendar days from date of receipt of initial request. • Notice of delay/deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision. **Practitioner/Member:** Written Notice of Action "Delay" notification within 14 calendar days from receipt of the initial request.
	Additional information received • If requested information is received, decision must be made within 5 business days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the initial request. .

[1] Business days = Monday through Friday excluding California State Holidays
https://www.calhr.ca.gov/employees/pages/state-holidays.aspx

Attachment A
TIMFRAMES FOR MEDI-CAL SERVICE DECISIONS AND NOTIFICATIONS

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Electronic or Written)**	**Electronic/Written Notification of <u>ADVERSE DETERMINATIONS</u> to Practitioner and Member**
	Additional information <u>incomplete or not received</u> If by 28 calendar days from the receipt of the initial request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial.	**<u>Practitioner</u>:** Within 24 hours of making the decision.	**<u>Practitioner</u>: Electronic** Within 24 hours of making the decision. **<u>Member</u>: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the initial request.
Expedited Authorization (Pre-Service) • Provider or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. • All necessary information received at time of initial request.	Approve, Deny, or Modify within 72 hours from receipt of the request.	**<u>Practitioner</u>:** Within 24 hours of making the decision.	**<u>Practitioner</u>: Electronic** Within 24 hours of making the decision. **<u>Member</u>: Written** Written notice within 72 hours from receipt of the request.
Expedited Authorization (Pre-Service) - Extension Needed • A request is extended when member or provider requests the extension, or CalOptima Health justifies a need for additional information and can demonstrate how the extension is in the member's best interest. There is reasonable likelihood that receipt of such information would lead to approval of the request.	Approve, Deny or Modify within 72 hours from receipt of the request **Additional clinical information required:** Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and member using the "delay" written notification, and insert specifics about what has not been received, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered **Note**: The time limit may be extended by up to 14 calendar days if the Member requests an extension, or CalOptima Health can provide justification upon request by the State	**<u>Practitioner</u>:** Within 24 hours of making the decision.	**<u>Practitioner</u>: Electronic** Within 24 hours of making the decision. **<u>Member</u>: Written** Written notice within 72 hours from the receipt of the request.

[1] Business days = Monday through Friday excluding California State Holidays
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UM TAT Revised: 01/22/2024

Attachment A
TIMFRAMES FOR MEDI-CAL SERVICE DECISIONS AND NOTIFICATIONS

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Electronic or Written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
	for the need for additional information and how it is in the Member's interest.		
	Additional information received • If requested information -is received, decision must be made within 1 business day of receipt of information.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
	Additional information incomplete or not received • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision.
Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	Approve, Modify, or Deny within 72 hours of receipt of the request. **Extension:** CalOptima Health may extend the time frame, by up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of inpatient treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	Approve, Modify, or Deny within 72 hours of last approved day or decision consistent with urgency of member's medical condition. **Extension:** CalOptima Health may extend the time frame 48 hours or up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner:** **Electronic or Oral:** Within 24 hours of receipt of the request. **Member: Written** Written notification within 2 business days of decision.

[1] Business days = Monday through Friday excluding California State Holidays
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UM TAT Revised: 01/22/2024

Attachment A

TIMFRAMES FOR MEDI-CAL SERVICE DECISIONS AND NOTIFICATIONS

		Notification Timeframe	
Type of Request	**Decision**	**Initial Notification (Notification May Be Electronic or Written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request).	Within 30 calendar days from receipt of request, that is reasonably necessary to make a decision.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 30 calendar days of receipt of the request. **Member: Written** Within 30 calendar days of receipt of request.
Hospice - Inpatient Care	Within 24 hours of receipt of request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.

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Attachment B

TIMFRAMES FOR ONECARE SERVICE DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Notification Timeframe
Standard Integrated Organization Determinations Prior Authorization/Prospective or outpatient service requests.	Approve, Modify or Deny no later than 14 calendar days from receipt of request. **Extensions: CalOptima Health may not extend deadlines for Integrated Organization Determinations.**	**Practitioner:** **Decision: Electronic or Written** Within 24 hours of making the decision. **Practitioner/Member: Written** Within 2 business days of decision. **Issue the Coverage Decision Notice for written notification of denial decision.**
Expedited Integrated Organization Determinations Prior Authorization/Prospective or outpatient service requests.	Approve, Modify or Deny expeditiously but no later than 72 hours from receipt of the request. CalOptima Health must request the necessary information from the noncontracted provider within 24 hours of the receipt request. **Extensions: CalOptima Health may not extend the deadlines for Integrated Organization Determinations.**	**Practitioner:** **Decision: Electronic or Oral Notification** Within 24 hours of making the decision. **Member: Oral** Within 24 hours of determination. **Practitioner/Member: Written** Within 2 business days of making the decision. When oral notification is given, it must be followed by written notification within 3 calendar days of the oral notification.
Expedited Authorization (Pre-Service) **If Expedited Criteria are not met**	If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. The 14-day period begins with the day the request was received for an expedited determination.	If request is not deemed to be expedited, CalOptima Health must notify member (within 72 hours) oral notification of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notification. ▪ **Use the Expedited Criteria Not Met** template to provide written notice. The written notice must include: 1) Explain that CalOptima Health will automatically transfer and process the request using the 14-day timeframe for standard determinations. 2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. 3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard

Includes weekends and holidays
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Attachment B

TIMFRAMES FOR ONECARE SERVICE DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Notification Timeframe
		timeframe for making determinations could seriously jeopardize the life or health of the member. 4) Provide instructions about the expedited grievance process and its time frames.
Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	Approve, Modify or Deny within 72 hours of the receipt of the request. **Extension:** CalOptima Health may extend the timeframe, by up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of inpatient treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	Approve, Modify or Deny within 72 hours of last approved day or decision consistent with urgency of member's medical condition. **Extension:** CalOptima Health may extend the time frame 48 hours or up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner/Member: Electronic or Oral** Within 24 hours of receipt of the request. **Practitioner/Member: Written** Within 3 calendar days of decision.
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Decision within 30 calendar days from receipt of request.	**Practitioner: Written** Within 30 calendar days of receipt of the request **Member: Written** Within 30 calendar days of receipt of request.
Hospice - Inpatient Care	Within 24 hours of receipt of request.	**Practitioner: Electronic or Oral** Within 24 hours of making the decision **Practitioner /Member: Written** Within 2 business days of making the decision

Includes weekends and holidays
UM TAT Revised: 01/22/2024

Attachment B

TIMFRAMES FOR ONECARE SERVICE DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Important Message (IM) from Medicare	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Hospitals are responsible for delivery of the Important Message from Medicare (IM): 1. Within 2 calendar days of admission to a hospital inpatient setting. 2. No more than 2 calendar days prior to discharge from a hospital inpatient setting. 3. CalOptima Health is responsible for the delivery of the Detailed Notice of Discharge (DND) when members appeal a discharge. 4. DND must be delivered no later than noon of the day after notification by QIO (Quality Improvement Organization)	Hospitals must issue IM within 2 calendar days of admission. Hospitals must issue IM no more than 2 calendar days prior to discharge from an inpatient stay.	CalOptima Health must issue the DND to both the member and QIO as early as possible but no later than noon of the day after notification by the QIO.

Includes weekends and holidays
UM TAT Revised: 01/22/2024

Continued to a Future Meeting

CalOptima Health Board Action Agenda Referral

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

Consent Calendar

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

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Kelly Giardina, MSG, CCM, Executive Director Clinical Operations, (657) 900-1013

Recommended Actions

Approve modifications to CalOptima Health Policy GG.1516: Hospital Acute Administrative Days, effective September 5, 2025.

Background/Discussion

CalOptima Health regularly reviews its policies and procedures to ensure they are up to date and aligned with federal and state health care program requirements, contractual obligations, laws, and CalOptima Operations.

Below is a description of the impacted policy, followed by a list of substantive changes to the policy, which are reflected in the redline policy included in Attachment 1. The list does not include non-substantive changes that may also be reflected in the redline (*e.g.*, formatting, spelling, punctuation, capitalization, minor clarifying language, and/or grammatical changes).

Policy GG.1516 Hospital Acute Administrative Days establishes the criteria for authorizing Acute Administrative Days (AAD) for CalOptima Health Direct Members. The policy was revised to improve the process for authorizing AAD for CalOptima Health Direct Members. The key changes include:

- **Alignment with Department of Health Care Services (DHCS) Requirements**: Ensuring full compliance with the DHCS administrative day requirements.
- **Updated Utilization Management (UM) Approach**: Enhancing coordination and facilitating more timely transitions to lower levels of care.
- **Removal of Previous Communication Methods:** Replacing the three manual calls and ten electronic requests with a combined new high-touch requirement of ten telephonic outreach calls.
- **Standardization Across Facilities:** Aiming to standardize AAD communication and transition outreach protocols across all hospital facilities.
- **Improved Clinical Oversight**: Supporting timely Skilled Nursing Facility (SNF) transitions and reducing AAD rates through better coordination and real-time clinical updates.

These changes are expected to streamline the process, improve clinical oversight, and ultimately reduce unnecessary administrative days.

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Policy Section	Change
Section II B.3.a	Removal of the following language: "ten (10) documented email, Electronic Medical Record or fax blast transition requests" to align with the TAR requirement for AAD.
Section II B.3.b	Removal of the following language: "or three (3) manual call attempts for placement per day" to align with the TAR requirement for AAD.
Section II.B.3.b	Updated language to reflect that all SNF placement requires ten (10) facility calls per weekday, vs SNF Level 1 to align with the TAR requirement for AAD.
Section III. A	Updated timeframe for when a facility is required to submit a request to CalOptima Health's UM Department once the discharge order is placed from 72 hours to 24 hours to align with the Medical Directors' internal decision.

Fiscal Impact

The recommended action to approve modifications to CalOptima Health GG.1516 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2025-26 Operating Budget.

Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, CalOptima Health staff recommends that the CalOptima Health Board of Directors approve and adopt revised CalOptima Health Policy GG.1516: Hospital Acute Administrative Days. The updated policies and procedures in Policy GG.1516 will supersede prior versions.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Health Policy: GG.1516: Hospital Acute Administrative Days

/s/ Michael Hunn *08/28/2025*
Authorized Signature **Date**

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Policy:	GG.1516
Title:	**Hospital Acute Administrative Days**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/*
Effective Date:	10/01/2000
Revised Date:	07/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☐ PACE

For 20250904 BOD Review Only

I. PURPOSE

This policy defines and establishes the criteria for authorizing Acute Administrative Days for CalOptima Health Direct Members.

II. POLICY

A. CalOptima Health's Utilization Management (UM) approves Acute Administrative Days following DHCS Treatment Authorization Request criteria for Acute Administrative Days as follows when:

1. A Member no longer meets acute hospital care criteria, and the Member meets Medical Necessity criteria for a transition to a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF) or subacute nursing facility, and the hospital has demonstrated Nursing Facility (NF) placement efforts as outlined in Section II.B.3. of this Policy.

2. A pregnant Member who does not require an acute level of care but has medical or nursing treatment needs that require medical and/or monitoring skills not available in any other setting.

3. A Member with confirmed or suspected Tuberculosis (TB) no longer meets an acute level of care but continues to require isolation to prevent the transmission or spread of TB disease to the community.

B. CalOptima Health considers the following factors when determining if a Member qualifies for Acute Administrative Days:

1. The industry standard criteria for determining level of care: Acute Administrative Days are authorized when a Member no longer meets acute hospital level of care services and meets skilled level of care with the intention to transition to a SNF, ICF or subacute nursing facility.

2. The type of services received by the Member in the acute care facility and the Medical Necessity of such services.

3. The acute care facility has made reasonable placement efforts, as evidenced by below outreach that includes at a minimum the date and time of contact, reason for denial and name of staff rendering decision:

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~~a. Ten (10) documented email, EMR or fax blast transition requests, or~~and

~~b. Three (3)~~Ten (10) ~~manual call attempts for placement per day.~~

~~c.~~a. Placement efforts, in the form of a call list. The call list should include the facility name and type, contact date, contact name, and the facility's response with a reason the bed is unavailable

~~d.~~b. AAD for SNF ~~Level 1~~ placement requires ten (10) facility calls per weekday (Monday through Friday).

i. Placement calls are not required on weekends and on state holidays (Christmas Eve and New Year's Eve are not considered state holidays).

ii. If there are no calls on Friday, or the call list is insufficient/incomplete, then Friday, Saturday, and Sunday may not be approved.

iii. If there are no calls or an insufficient/incomplete call list on the day prior to a holiday, then that day and the holiday may not be approved

4. Authorized Acute Administrative Days shall be paid in accordance with CalOptima Health Policy FF.1004: Payments for Hospitals Contracted to Serve a CalOptima Health Direct-Administrative Member, CalOptima Health Community Network Member, or a Member Enrolled in a Shared Risk Group.

III. PROCEDURE

A. Upon identification of a Member who no longer meets acute hospital care criteria and continues to remain in an acute care Facility, CalOptima Health reviews Acute Administrative Days prospectively. Within twenty-four (~~72~~24) hours of the discharge order, t~~T~~he facility is required to submit a request with medical documentation to CalOptima Health's UM Department of the Member's medical condition, type of services received, and documentation of reasonable placement efforts.

1. Upon receipt of the above, CalOptima Health's UM Department staff will review the medical documentation, including documentation of required attempts to place Member with CalOptima Health's Medical Director for determination. CalOptima Health shall notify the acute care facility, in writing, of its decision, in accordance with timeframes set forth in CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

2. The acute care facility may appeal CalOptima Health's UM decision, in accordance with CalOptima Health Policies GG.1510: Member Appeal Process and MA.9006: Contracted Provider Complaint Process.

3. Hospital Acute Administrative Days are not covered under the following circumstances:

a. Custodial level of care;

b. Lack of timely or adequate discharge planning;

c. Incomplete documentation of placement efforts;

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d. Social/family issues which delay or prevent placement;

e. Delay in Nursing Facility (NF) transfer due to awaiting legal conservatorship; or

f. Member does not require skilled nursing level of care.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy FF.1004: Payment for Hospitals Contracted to Serve a CalOptima Health Direct Member, CalOptima Health Community Network Member, or a Member Enrolled in a Shared Risk Group
C. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
D. CalOptima Health Policy GG.1510: Member Appeal Process
E. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
F. Medi-Cal Provider Manual Part 2, Treatment Authorization Request (TAR) Criteria for Acute Administrative Days (AAD)
G. Title 22, California Code of Regulations (CCR), § 51342

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/10/2014	Department of Health Care Services (DHCS)	Approved as Submitted
12/06/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2000	GG.1516	Acute Administrative Days	Medi-Cal
Revised	07/01/2007	GG.1516	Acute Administrative Days	Medi-Cal
Revised	12/01/2013	GG.1516	Acute Administrative Days	Medi-Cal
Revised	11/01/2015	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	10/01/2016	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	08/01/2017	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	12/01/2018	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	06/01/2020	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	06/01/2021	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/31/2022	GG.1516	Acute Administrative Days	Medi-Cal OneCare
Revised	11/01/2023	GG.1516	Hospital Acute Administrative Days	Medi-Cal OneCare
Revised	12/31/2024	GG.1516	Hospital Acute Administrative Days	Medi-Cal OneCare
Revised	07/01/2025	GG.1516	Hospital Acute Administrative Days	Medi-Cal OneCare

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IX. GLOSSARY

Term	Definition
Acute Administrative Days	An authorized inpatient day for a Member who no longer meets medical criteria for inpatient services at an acute care hospital and is unsafe for discharge based on pending placement or Social Needs.~~An authorized inpatient day for a Member who no longer meets medical criteria for inpatient services at an acute care hospital, qualifies for Nursing Facility Level of Care and is unable to discharge based on securing placement.~~
CalOptima Health Direct (COHD)	A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members);

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For 2025

Term	Definition
	6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012.Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

For 2025

Term	Definition
	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Intermediate Care Facility (ICF)	Medi-Cal: A residential facility certified and licensed by the State to provide medical services at a lower level of care than is provided at Skilled Nursing Facilities (SNFs), and meets the standards specified in 22 CCR section 51212. An Intermediate Care Facility for the Developmentally Disabled (ICF/DD) includes the following types: 1. ICF/DD – Habilitative as defined in Health and Safety Code (H&S) section 1250(e); 2. ICF/DD – Nursing as defined in H&S section 1250(h); and 3. ICF/DD as defined in H&S section 1250(g) and does not include the ICF/DD Continuous Nursing Care Program. ~~A health facility that is licensed as such by the Department of Health Care Services (DHCS) or is a hospital or SNF that meets the standards specified in Title 22, California Code of Regulations, Section 51212, and has been certified by DHCS for participation in the Medi-Cal program.~~ OneCare: ~~Intermediate Care Facility (ICF):~~ A facility that primarily provides health-related care and services above the level of custodial care but does not provide the level of care available in a hospital or Skilled Nursing Facility.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	A beneficiary enrolled in a CalOptima Health program.

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Term	Definition
Skilled Nursing Facility (SNF)	Medi-Cal: Any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal program. OneCare: A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

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Policy:	GG.1516
Title:	**Hospital Acute Administrative Days**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/*
Effective Date:	10/01/2000
Revised Date:	07/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☐ PACE

For 20250904 BOD Review Only

I. PURPOSE

This policy defines and establishes the criteria for authorizing Acute Administrative Days for CalOptima Health Direct Members.

II. POLICY

A. CalOptima Health's Utilization Management (UM) approves Acute Administrative Days following DHCS Treatment Authorization Request criteria for Acute Administrative Days as follows when:

1. A Member no longer meets acute hospital care criteria, and the Member meets Medical Necessity criteria for a transition to a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF) or subacute nursing facility, and the hospital has demonstrated Nursing Facility (NF) placement efforts as outlined in Section II.B.3. of this Policy.

2. A pregnant Member who does not require an acute level of care but has medical or nursing treatment needs that require medical and/or monitoring skills not available in any other setting.

3. A Member with confirmed or suspected Tuberculosis (TB) no longer meets an acute level of care but continues to require isolation to prevent the transmission or spread of TB disease to the community.

B. CalOptima Health considers the following factors when determining if a Member qualifies for Acute Administrative Days:

1. The industry standard criteria for determining level of care: Acute Administrative Days are authorized when a Member no longer meets acute hospital level of care services and meets skilled level of care with the intention to transition to a SNF, ICF or subacute nursing facility.

2. The type of services received by the Member in the acute care facility and the Medical Necessity of such services.

3. The acute care facility has made reasonable placement efforts, as evidenced by below outreach that includes at a minimum the date and time of contact, reason for denial and name of staff rendering decision:

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a. Placement efforts, in the form of a call list. The call list should include the facility name and type, contact date, contact name, and the facility's response with a reason the bed is unavailable

b. AAD for SNF placement requires ten (10) facility calls per weekday (Monday through Friday).

i. Placement calls are not required on weekends and on state holidays (Christmas Eve and New Year's Eve are not considered state holidays).

ii. If there are no calls on Friday, or the call list is insufficient/incomplete, then Friday, Saturday, and Sunday may not be approved.

iii. If there are no calls or an insufficient/incomplete call list on the day prior to a holiday, then that day and the holiday may not be approved

4. Authorized Acute Administrative Days shall be paid in accordance with CalOptima Health Policy FF.1004: Payments for Hospitals Contracted to Serve a CalOptima Health Direct-Administrative Member, CalOptima Health Community Network Member, or a Member Enrolled in a Shared Risk Group.

III. PROCEDURE

A. Upon identification of a Member who no longer meets acute hospital care criteria and continues to remain in an acute care Facility, CalOptima Health reviews Acute Administrative Days prospectively. Within twenty-four (24) hours of the discharge order, the facility is required to submit a request with medical documentation to CalOptima Health's UM Department of the Member's medical condition, type of services received, and documentation of reasonable placement efforts.

1. Upon receipt of the above, CalOptima Health's UM Department staff will review the medical documentation, including documentation of required attempts to place Member with CalOptima Health's Medical Director for determination. CalOptima Health shall notify the acute care facility, in writing, of its decision, in accordance with timeframes set forth in CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

2. The acute care facility may appeal CalOptima Health's UM decision, in accordance with CalOptima Health Policies GG.1510: Member Appeal Process and MA.9006: Contracted Provider Complaint Process.

3. Hospital Acute Administrative Days are not covered under the following circumstances:

a. Custodial level of care;

b. Lack of timely or adequate discharge planning;

c. Incomplete documentation of placement efforts;

d. Social/family issues which delay or prevent placement;

e. Delay in Nursing Facility (NF) transfer due to awaiting legal conservatorship; or

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f. Member does not require skilled nursing level of care.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy FF.1004: Payment for Hospitals Contracted to Serve a CalOptima Health Direct Member, CalOptima Health Community Network Member, or a Member Enrolled in a Shared Risk Group
C. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
D. CalOptima Health Policy GG.1510: Member Appeal Process
E. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
F. Medi-Cal Provider Manual Part 2, Treatment Authorization Request (TAR) Criteria for Acute Administrative Days (AAD)
G. Title 22, California Code of Regulations (CCR), § 51342

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/10/2014	Department of Health Care Services (DHCS)	Approved as Submitted
12/06/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2000	GG.1516	Acute Administrative Days	Medi-Cal
Revised	07/01/2007	GG.1516	Acute Administrative Days	Medi-Cal
Revised	12/01/2013	GG.1516	Acute Administrative Days	Medi-Cal
Revised	11/01/2015	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	10/01/2016	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	08/01/2017	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	12/01/2018	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	06/01/2020	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	06/01/2021	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	12/31/2022	GG.1516	Acute Administrative Days	Medi-Cal OneCare

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Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2023	GG.1516	Hospital Acute Administrative Days	Medi-Cal OneCare
Revised	12/31/2024	GG.1516	Hospital Acute Administrative Days	Medi-Cal OneCare
Revised	07/01/2025	GG.1516	Hospital Acute Administrative Days	Medi-Cal OneCare

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For 20250904 BOD Review Only

IX. GLOSSARY

Term	Definition
Acute Administrative Days	An authorized inpatient day for a Member who no longer meets medical criteria for inpatient services at an acute care hospital and is unsafe for discharge based on pending placement or Social Needs.
CalOptima Health Direct (COHD)	A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis);

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Term	Definition
	7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012.Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.

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Term	Definition
Intermediate Care Facility (ICF)	Medi-Cal: A residential facility certified and licensed by the State to provide medical services at a lower level of care than is provided at Skilled Nursing Facilities (SNFs), and meets the standards specified in 22 CCR section 51212. An Intermediate Care Facility for the Developmentally Disabled (ICF/DD) includes the following types: 1. ICF/DD – Habilitative as defined in Health and Safety Code (H&S) section 1250(e); 2. ICF/DD – Nursing as defined in H&S section 1250(h); and 3. ICF/DD as defined in H&S section 1250(g) and does not include the ICF/DD Continuous Nursing Care Program. OneCare: A facility that primarily provides health-related care and services above the level of custodial care but does not provide the level of care available in a hospital or Skilled Nursing Facility.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	A beneficiary enrolled in a CalOptima Health program.
Skilled Nursing Facility (SNF)	Medi-Cal: Any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal program.

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Term	Definition
	OneCare: A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

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CalOptima Health Board Action Agenda Referral

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

Consent Calendar

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

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions

Approve amendments to the following operations policies and procedures:

1. Policy DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment; and

2. Policy EE.1101: Additions, Changes, and Terminations to CalOptima Health Provider Information.

Background

CalOptima Health is committed to ensuring its members have access to continuous care with their identified primary care provider (PCP). In line with this commitment, CalOptima Health proposes the below changes to the operational processes when a PCP requests to terminate its contract with CalOptima Health Community Network (CHCN) and termination would impact continuity of care for a subset of members with specific health conditions who must remain in CHCN. These changes are intended to improve member experience and support continuity of care and outcomes for the impacted members. Additionally, this process will mitigate delays in patient care as a direct result of members having to establish new patient-to-provider relationships due to the current PCP termination process.

Staff recommends the following updates to policies DD.2006b and EE.1101:

1. **Policy DD.2006b: CalOptima Community Network Member Primary Care Provider Selection/ Assignment** describes the criteria by which a CHCN member selects or is assigned a PCP.
    - The proposed update clarifies that members diagnosed with certain conditions will be allowed the option to remain with a CHCN PCP as long as the PCP continues its contract with CHCN to provide covered services to impacted members. The proposed updates do not affect the criteria for those members that qualify for this continuity-of-care arrangement.
    - In the situation where the PCP for the impacted members fully terminates its contract with CalOptima, the member will be assigned to a new PCP of the member's choice or auto-assigned in the absence of member choice.

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2. **Policy EE.1101: Additions, Changes, and Terminations to CalOptima Health Provider Information** describes the guidelines and criteria by which CalOptima Health adds, changes, and terminates requests for providers in CHCN and health networks to support coordination of care, ensure network adequacy management, accuracy of primary care membership assignment, and the provider directories. Provider terminations under this policy may impact member populations defined in Policy DD.2006b.
    - The proposed updates define the policy and process for a CHCN PCP who has members assigned to them fitting the description defined in the policy DD.2006b, as summarized above.
    - The updates require PCPs who request to terminate with CHCN but who will remain a CalOptima Health provider through a Health Network, to retain their CHCN contract to continue to see the impacted members.
    - The policy also clarifies that a specialist who terminates their contract with CHCN may continue to see the impacted members through a letter of agreement.
    - Other non-substantive changes (*i.e.*, formatting, clarifying languages, grammatical changes, document flow).

These policy changes will not impact the PCP termination process for all other Health Networks. Staff proposes making these updates effective upon Board approval.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2025-26 Operating Budget.

Rationale for Recommendation
The above recommended actions will reinforce CalOptima Health's continued commitment to its members and their ability to maintain continuity of care with their chosen PCP.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Health Policy DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment
2. CalOptima Health Policy EE.1101: Additions, Changes, and Terminations to CalOptima Health Provider Information

/s/ Michael Hunn *08/28/2025*
Authorized Signature **Date**

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Policy:	DD.2006b
Title:	**CalOptima Health Community Network Member Primary Care Provider Selection/Assignment**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2011
Revised Date:	08/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy describes the criteria by which a CalOptima Health Community Network (CHCN) Member shall select or be assigned a Primary Care Provider (PCP).

II. POLICY

A. CalOptima Health recognizes that it is in the best interest of a Member to establish a medical home and maintain continuity of care with a PCP.

B. As part of CalOptima Health's commitment to these objectives, a CHCN Member is encouraged to select a participating PCP in accordance with the terms and conditions of this policy. If a CHCN Member does not select a participating PCP, CalOptima Health shall assign the Member to a participating PCP in accordance with this policy.

C. CalOptima Health shall only assign a Member to a participating PCP who has been credentialed as a PCP by CalOptima Health.

D. A Member shall have the right to select a participating Community Health Center or Non-Physician Medical Practitioner as his or her PCP. If a Member chooses a participating Non-Physician Medical Practitioner as his or her PCP, the Member shall be assigned directly to the supervising physician and not the Non-Physician Medical Practitioner.

E. A Member categorized as a Senior or Person with a Disability (SPD) shall have the right to choose a PCP specialist physician who is a participating Provider, is willing to perform the role of the PCP, and has met CalOptima Health's requirements for a specialist to act as a PCP.

F. A Member eligible for the California Children's Services (CCS) Program, or the Member's parent(s), custodial parent(s), legal guardian(s), or other Authorized Representative(s), shall have the right to request a specialist as a PCP if the specialist agrees to serve in a PCP role and is a CCS-paneled Provider qualified to treat the required range of CCS-Eligible Conditions of the CCS child or youth, in accordance with CCS program rules and regulations.

G. CalOptima Health shall maintain the existing PCP assignment process for the Adult Expansion Population by designating a point of contact to coordinate with county uninsured programs and public health care systems to share data and use that data to effectuate PCP ~~assignment~~assignments.

1. CalOptima Health shall identify unique individuals in the county uninsured programs or public health care systems by Client Index Number (CIN). If the CIN is not available, other data elements shall be used such as name, date of birth, and address.

2. CalOptima Health shall send the Member PCP Assignment file with all the data elements outlined in the data transmission requirements, outlined in DHCS APL 23-031: Medi-Cal Managed Care Plan Implementation of Primary Care Provider Assignment for the Age 26-49 Adult Expansion Transition, to the county uninsured programs and public health care systems.

3. CalOptima Health shall receive data for the Adult Expansion Population from county uninsured programs and public health care systems to match PCP assignments for new and transitioning Members. CalOptima Health shall use the data elements provided to complete a Member match and PCP assignment.

4. CalOptima Health shall return the PCP Assignment Return File to the county uninsured programs and/or public health systems of the Members successfully assigned a PCP match.

5. CalOptima Health shall not preclude assignment based on a PCP having a closed panel or not accepting new Members.

6. CalOptima Health shall receive, store, use, or transmit PHI and share data, in accordance with CalOptima Health Policy HH.3023: Information Sharing.

7. CalOptima Health shall securely destroy data for individuals who do not ultimately enroll into CalOptima Health, in accordance with CalOptima Health Policy GA.3201: Document Management Program and with Health Insurance Portability and Accountability Act (HIPAA) regulations.

H. CalOptima Health shall make reasonable efforts to ensure that a Member expressing a desire to continue his or her existing relationship with a participating CHCN PCP is assigned to such PCP.

I. A Member who selects or is assigned to a participating Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as his or her PCP:

1. Shall be assigned directly to the FQHC or RHC; and

2. Shall not be assigned to an individual PCP performing services on behalf of the FQHC or RHC.

J. American Indian Members may choose an American Indian Health Care Provider within CalOptima Health's contracted network as his or her PCP.

K. CalOptima Health shall disclose to a Member the reason for which he or she could not select or be assigned to a specific PCP.

L. A Member may change his or her CHCN-participating PCP once every thirty (30) calendar days in accordance with this policy.

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M. CalOptima Health shall notify the CHCN PCP via the provider portal that they have been selected by a Member, or that they have been assigned a Member by CalOptima Health, within ten (10) calendar days after completion of the selection or assignment.

N. If a participating PCP terminates the contractual relationship with CHCN, CalOptima Health shall assign impacted Members to a new PCP of the Member's choice. In the absence of Member choice, if the PCP requests to maintain the relationship with the Member, the Member shall be assigned to a Health Network of the PCP's choice.

1. Members diagnosed with the following conditions shall remain with CHCN and may continue with their current PCP if the PCP is contracted to see Members with the conditions outlined below. If the PCP is not contracted with CalOptima Health, the Member shall be assigned to a new PCP of the Member's choice or auto assigned in the absence of Member choice:

   a. Diagnosed with hemophilia;

   b. A Member with a Breast and Cervical Cancer Treatment Program (BCCTP) Primary Aid Code;

   c. Listed for a Major Organ Transplant or approved for a Bone Marrow Transplant (BMT);

   d. Has received a Major Organ Transplant or BMT within one hundred twenty (120) calendar days prior to the Member's effective date of enrollment in CalOptima Health; or

   e. Is diagnosed with End Stage Renal Disease (ESRD).

O. CalOptima Health shall provide written notice of termination of a contracted Provider to each Member in accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services.

III. PROCEDURE

A. PCP Selection or Assignment for a Newly Enrolled CHCN Member

1. A newly eligible Member who chooses CHCN or is Auto-Assigned to CHCN shall have thirty (30) calendar days to select a CHCN participating PCP, or up to forty-five (45) calendar days if the Member's date of eligibility with CalOptima Health Direct (COHD) was after the fifteenth (15th) calendar day in the eligibility month.

2. A Member assigned directly to CHCN, in accordance with CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct, shall be assigned a PCP in accordance with the terms of this policy.

3. If an Adult Expansion Population Member's PCP data is received from the county uninsured programs and public health care systems, CalOptima Health shall assign the member to the PCP listed in the PCP Assignment File.

4. If a Member does not select a participating PCP as described in Section III.A.1 of this Policy, or for a Member assigned directly to CHCN as described in Section III.A.2 of this Policy, CalOptima Health shall assign the Member to a participating PCP based on the following criteria:

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a. If the Member was eligible with CalOptima Health within the last three hundred sixty-five (365) calendar days, CalOptima Health shall assign the Member to the last PCP on record that is currently a CHCN-participating PCP.

b. If the Member does not meet criteria outlined in Section III.A.4.a and has a family Member in CHCN, CalOptima Health shall assign the Member to the same PCP, subject to any age and gender restrictions applicable to the PCP.

5. Notwithstanding the above, if an SPD or a CCS Member does not select a CHCN-participating PCP, CalOptima Health shall use Fee-For-Service (FFS) utilization data or other data sources (including electronic data), if available, for purposes of PCP assignment.

6. In the event Sections III.A.3-4 do not apply, CalOptima Health shall assign the Member to a participating PCP open for new assignment based on the following:

a. The geographic location of the participating PCP's office in relation to the Member's residence, in accordance with CalOptima Health Policy GG.1600: Access and Availability Standards;

b. The Member's language; then

c. The Member's age.

d. If more than one (1) PCP meets all assignment criteria, a PCP will be assigned based on a rotation to allow balanced distribution.

B. For a PCP who terminates from CHCN and requests to maintain the relationship with the Member;

1. The Provider shall submit a written request to CalOptima Health's Provider Relations Department at least sixty (60) calendar days prior to the expected date of termination including the Health Network name for Member assignment as appropriate.

2. CalOptima Health shall provide written notification to the Member in accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services.

3. If the Provider is contracted with CalOptima Health to continue seeing Members with certain diagnosis as described in Section II.N.1. of this policy, no change in Member's PCP assignment will occur unless requested by Member.

~~3.~~4. In the absence of Member choice, CalOptima Health shall maintain the Member's relationship with the current PCP and the Health Network selected by the PCP.

~~4.~~5. The effective date of the change shall be the first (1st) of the month following the date of the PCP termination.

C. If a Member selects a participating PCP that is not accepting new Members, CalOptima Health shall:

1. Inform the Member to choose a participating PCP to avoid Auto-Assignment.

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2. Contact the PCP, if a Member contacts CalOptima Health and indicates an existing relationship with a participating PCP not accepting new Members and make all reasonable efforts to ensure that the Member may continue an existing relationship with the participating PCP.

3. Assign the Member to a CHCN-participating PCP, in accordance with Section III.A. of this policy, if CalOptima Health is unable to obtain a CHCN-participating PCP from the Member.

D. A Member may request to change his or her participating PCP every thirty (30) calendar days by contacting CalOptima Health's Customer Service Department.

1. If the Member requests a PCP change before seeing his or her assigned PCP prior to the sixteenth (16th) calendar day of the current month, CalOptima Health shall make the change effective the first (1st) calendar day of the current month.

2. If the Member requests a PCP change after seeing his or her assigned PCP after the sixteenth (16th) calendar day of the current month, CalOptima Health shall make the change effective the first (1st) calendar day of the immediately following month.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Community Network (CHCN) Primary Care Provider (PCP) Selection Form and Guide
B. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health Contract for Health Care Services
D. CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct
E. CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services
F. CalOptima Health Policy GA.3201: Document Management Program
G. CalOptima Health Policy GG.1600: Access and Availability Standards
H. CalOptima Health Policy HH.3023: Information Sharing
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-031: Medi-Cal Managed Care Plan Implementation of Primary Care Provider Assignment for the Age 26-49 Adult Expansion Transition
J. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~23-034~~24-015: California Children's Services Whole Child Model Program (Supersedes APL ~~21-005)~~23-034)
K. Welfare and Institutions Code, §§ 14087.325 and 14094.14
L. Title 22, California Code of Regulations (CCR), §55170
M. Title 42, Code of Federal Regulations (CFR), §438.10(f)(5)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/12/2010	Department of Health Care Services (DHCS)	Approved as Submitted
04/07/2015	Department of Health Care Services (DHCS)	Approved as Submitted
10/09/2017	Department of Health Care Services (DHCS)	Approved as Submitted
09/17/2018	Department of Health Care Services (DHCS)	Approved as Submitted
06/05/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/16/2024	Department of Health Care Services (DHCS)	Approved as Submitted

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VII. BOARD ACTION(S)

Date	Meeting
11/05/2009	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2011	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
~~Revised~~	~~03/01/2011~~	~~DD.2006b~~	~~CalOptima Care Network Member Primary Care Provider Selection/Assignment~~	~~Medi-Cal~~
Revised	07/01/2011	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	01/01/2013	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	03/01/2015	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/01/2016	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/01/2017	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/06/2018	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/01/2019	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	08/01/2020	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	10/01/2021	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/01/2022	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	05/01/2023	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	04/01/2024	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	12/05/2024	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	08/01/2025	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal

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IX. GLOSSARY

Term	Definition
Adult Expansion Population	An expansion population as defined by amended Welfare and Institutions Code (W&I) Section 14007.8 for full scope Medi-Cal to individuals who are twenty-six (26) through forty-nine (49) years of age, and who do not have satisfactory immigration status (SIS) as required by W&I Section 14011.2.
Authorized Representative	Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Auto-Assignment	The process by which a CalOptima Health Member who does not select a PCP and/or Health Network is assigned to a participating CalOptima Health Provider and/or Health Network.
California Children's Services (CCS)-Eligible Condition	A medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 et seq.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Member.
CalOptima Health Direct (COHD) Member	A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network; and 3. Ability to function as a Primary Care Provider (PCP).
Covered Services	Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, this Contract, and APLs that are made the responsibility of Contractor pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS)

For 20250904 BOD Review Only

Term	Definition
	Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under this Contract, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than 21 years of age. Contractor is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, Contractor is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, Contractor is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than 21 years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, Contractor must ensure access to comparable services under the EPSDT benefit in accordance with APL 23-005;

For 2025

Term	Definition
	14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with APL 22-012.
Federally Qualified Health Center (FQHC)	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).
Member	For the purposes of this policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal, or the United States Social Security Administration, who is enrolled in the CalOptima Health program and the CalOptima Health Community Network.
Non-Physician Medical Practitioner	A nurse midwife, physician's assistant, or nurse practitioner who provides primary care.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Rural Health Clinic (RHC)	An entity defined in Title 22 CCR Section 51115.5.
Seniors and Persons with Disabilities (SPD)	Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.

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Policy:	DD.2006b
Title:	**CalOptima Health Community Network Member Primary Care Provider Selection/Assignment**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2011
Revised Date:	08/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☐ OneCare ☐ PACE

For 20250904 BOD Review Only

I. PURPOSE

This policy describes the criteria by which a CalOptima Health Community Network (CHCN) Member shall select or be assigned a Primary Care Provider (PCP).

II. POLICY

A. CalOptima Health recognizes that it is in the best interest of a Member to establish a medical home and maintain continuity of care with a PCP.

B. As part of CalOptima Health's commitment to these objectives, a CHCN Member is encouraged to select a participating PCP in accordance with the terms and conditions of this policy. If a CHCN Member does not select a participating PCP, CalOptima Health shall assign the Member to a participating PCP in accordance with this policy.

C. CalOptima Health shall only assign a Member to a participating PCP who has been credentialed as a PCP by CalOptima Health.

D. A Member shall have the right to select a participating Community Health Center or Non-Physician Medical Practitioner as his or her PCP. If a Member chooses a participating Non-Physician Medical Practitioner as his or her PCP, the Member shall be assigned directly to the supervising physician and not the Non-Physician Medical Practitioner.

E. A Member categorized as a Senior or Person with a Disability (SPD) shall have the right to choose a PCP specialist physician who is a participating Provider, is willing to perform the role of the PCP, and has met CalOptima Health's requirements for a specialist to act as a PCP.

F. A Member eligible for the California Children's Services (CCS) Program, or the Member's parent(s), custodial parent(s), legal guardian(s), or other Authorized Representative(s), shall have the right to request a specialist as a PCP if the specialist agrees to serve in a PCP role and is a CCS-paneled Provider qualified to treat the required range of CCS-Eligible Conditions of the CCS child or youth, in accordance with CCS program rules and regulations.

G. CalOptima Health shall maintain the existing PCP assignment process for the Adult Expansion Population by designating a point of contact to coordinate with county uninsured programs and public health care systems to share data and use that data to effectuate PCP assignments.

1. CalOptima Health shall identify unique individuals in the county uninsured programs or public health care systems by Client Index Number (CIN). If the CIN is not available, other data elements shall be used such as name, date of birth, and address.

2. CalOptima Health shall send the Member PCP Assignment file with all the data elements outlined in the data transmission requirements, outlined in DHCS APL 23-031: Medi-Cal Managed Care Plan Implementation of Primary Care Provider Assignment for the Age 26-49 Adult Expansion Transition, to the county uninsured programs and public health care systems.

3. CalOptima Health shall receive data for the Adult Expansion Population from county uninsured programs and public health care systems to match PCP assignments for new and transitioning Members. CalOptima Health shall use the data elements provided to complete a Member match and PCP assignment.

4. CalOptima Health shall return the PCP Assignment Return File to the county uninsured programs and/or public health systems of the Members successfully assigned a PCP match.

5. CalOptima Health shall not preclude assignment based on a PCP having a closed panel or not accepting new Members.

6. CalOptima Health shall receive, store, use, or transmit PHI and share data, in accordance with CalOptima Health Policy HH.3023: Information Sharing.

7. CalOptima Health shall securely destroy data for individuals who do not ultimately enroll into CalOptima Health, in accordance with CalOptima Health Policy GA.3201: Document Management Program and with Health Insurance Portability and Accountability Act (HIPAA) regulations.

H. CalOptima Health shall make reasonable efforts to ensure that a Member expressing a desire to continue his or her existing relationship with a participating CHCN PCP is assigned to such PCP.

I. A Member who selects or is assigned to a participating Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as his or her PCP:

1. Shall be assigned directly to the FQHC or RHC; and

2. Shall not be assigned to an individual PCP performing services on behalf of the FQHC or RHC.

J. American Indian Members may choose an American Indian Health Care Provider within CalOptima Health's contracted network as his or her PCP.

K. CalOptima Health shall disclose to a Member the reason for which he or she could not select or be assigned to a specific PCP.

L. A Member may change his or her CHCN-participating PCP once every thirty (30) calendar days in accordance with this policy.

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M. CalOptima Health shall notify the CHCN PCP via the provider portal that they have been selected by a Member, or that they have been assigned a Member by CalOptima Health, within ten (10) calendar days after completion of the selection or assignment.

N. If a participating PCP terminates the contractual relationship with CHCN, CalOptima Health shall assign impacted Members to a new PCP of the Member's choice. In the absence of Member choice, if the PCP requests to maintain the relationship with the Member, the Member shall be assigned to a Health Network of the PCP's choice.

1. Members diagnosed with the following conditions shall remain with CHCN and may continue with their current PCP if the PCP is contracted to see Members with the conditions outlined below. If the PCP is not contracted with CalOptima Health, the Member shall be assigned to a new PCP of the Member's choice or auto assigned in the absence of Member choice:

   a. Diagnosed with hemophilia;

   b. A Member with a Breast and Cervical Cancer Treatment Program (BCCTP) Primary Aid Code;

   c. Listed for a Major Organ Transplant or approved for a Bone Marrow Transplant (BMT);

   d. Has received a Major Organ Transplant or BMT within one hundred twenty (120) calendar days prior to the Member's effective date of enrollment in CalOptima Health; or

   e. Is diagnosed with End Stage Renal Disease (ESRD).

O. CalOptima Health shall provide written notice of termination of a contracted Provider to each Member in accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services.

III. PROCEDURE

A. PCP Selection or Assignment for a Newly Enrolled CHCN Member

1. A newly eligible Member who chooses CHCN or is Auto-Assigned to CHCN shall have thirty (30) calendar days to select a CHCN participating PCP, or up to forty-five (45) calendar days if the Member's date of eligibility with CalOptima Health Direct (COHD) was after the fifteenth (15th) calendar day in the eligibility month.

2. A Member assigned directly to CHCN, in accordance with CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct, shall be assigned a PCP in accordance with the terms of this policy.

3. If an Adult Expansion Population Member's PCP data is received from the county uninsured programs and public health care systems, CalOptima Health shall assign the member to the PCP listed in the PCP Assignment File.

4. If a Member does not select a participating PCP as described in Section III.A.1 of this Policy, or for a Member assigned directly to CHCN as described in Section III.A.2 of this Policy, CalOptima Health shall assign the Member to a participating PCP based on the following criteria:

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a. If the Member was eligible with CalOptima Health within the last three hundred sixty-five (365) calendar days, CalOptima Health shall assign the Member to the last PCP on record that is currently a CHCN-participating PCP.

b. If the Member does not meet criteria outlined in Section III.A.4.a and has a family Member in CHCN, CalOptima Health shall assign the Member to the same PCP, subject to any age and gender restrictions applicable to the PCP.

5. Notwithstanding the above, if an SPD or a CCS Member does not select a CHCN-participating PCP, CalOptima Health shall use Fee-For-Service (FFS) utilization data or other data sources (including electronic data), if available, for purposes of PCP assignment.

6. In the event Sections III.A.3-4 do not apply, CalOptima Health shall assign the Member to a participating PCP open for new assignment based on the following:

a. The geographic location of the participating PCP's office in relation to the Member's residence, in accordance with CalOptima Health Policy GG.1600: Access and Availability Standards;

b. The Member's language; then

c. The Member's age.

d. If more than one (1) PCP meets all assignment criteria, a PCP will be assigned based on a rotation to allow balanced distribution.

B. For a PCP who terminates from CHCN and requests to maintain the relationship with the Member;

1. The Provider shall submit a written request to CalOptima Health's Provider Relations Department at least sixty (60) calendar days prior to the expected date of termination including the Health Network name for Member assignment as appropriate.

2. CalOptima Health shall provide written notification to the Member in accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services.

3. If the Provider is contracted with CalOptima Health to continue seeing Members with certain diagnosis as described in Section II.N.1. of this policy, no change in Member's PCP assignment will occur unless requested by Member.

4. In the absence of Member choice, CalOptima Health shall maintain the Member's relationship with the current PCP and the Health Network selected by the PCP.

5. The effective date of the change shall be the first (1st) of the month following the date of the PCP termination.

C. If a Member selects a participating PCP that is not accepting new Members, CalOptima Health shall:

1. Inform the Member to choose a participating PCP to avoid Auto-Assignment.

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2. Contact the PCP, if a Member contacts CalOptima Health and indicates an existing relationship with a participating PCP not accepting new Members and make all reasonable efforts to ensure that the Member may continue an existing relationship with the participating PCP.

3. Assign the Member to a CHCN-participating PCP, in accordance with Section III.A. of this policy, if CalOptima Health is unable to obtain a CHCN-participating PCP from the Member.

D. A Member may request to change his or her participating PCP every thirty (30) calendar days by contacting CalOptima Health's Customer Service Department.

1. If the Member requests a PCP change before seeing his or her assigned PCP prior to the sixteenth (16th) calendar day of the current month, CalOptima Health shall make the change effective the first (1st) calendar day of the current month.

2. If the Member requests a PCP change after seeing his or her assigned PCP after the sixteenth (16th) calendar day of the current month, CalOptima Health shall make the change effective the first (1st) calendar day of the immediately following month.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Community Network (CHCN) Primary Care Provider (PCP) Selection Form and Guide
B. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health Contract for Health Care Services
D. CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct
E. CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services
F. CalOptima Health Policy GA.3201: Document Management Program
G. CalOptima Health Policy GG.1600: Access and Availability Standards
H. CalOptima Health Policy HH.3023: Information Sharing
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-031: Medi-Cal Managed Care Plan Implementation of Primary Care Provider Assignment for the Age 26-49 Adult Expansion Transition
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
K. Welfare and Institutions Code, §§ 14087.325 and 14094.14
L. Title 22, California Code of Regulations (CCR), §55170
M. Title 42, Code of Federal Regulations (CFR), §438.10(f)(5)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/12/2010	Department of Health Care Services (DHCS)	Approved as Submitted
04/07/2015	Department of Health Care Services (DHCS)	Approved as Submitted
10/09/2017	Department of Health Care Services (DHCS)	Approved as Submitted
09/17/2018	Department of Health Care Services (DHCS)	Approved as Submitted
06/05/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/16/2024	Department of Health Care Services (DHCS)	Approved as Submitted

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VII. BOARD ACTION(S)

Date	Meeting
11/05/2009	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2011	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	07/01/2011	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	01/01/2013	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	03/01/2015	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/01/2016	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/01/2017	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/06/2018	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/01/2019	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	08/01/2020	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	10/01/2021	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/01/2022	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	05/01/2023	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2024	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	12/05/2024	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	08/01/2025	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal

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IX. GLOSSARY

Term	Definition
Adult Expansion Population	An expansion population as defined by amended Welfare and Institutions Code (W&I) Section 14007.8 for full scope Medi-Cal to individuals who are twenty-six (26) through forty-nine (49) years of age, and who do not have satisfactory immigration status (SIS) as required by W&I Section 14011.2.
Authorized Representative	Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Auto-Assignment	The process by which a CalOptima Health Member who does not select a PCP and/or Health Network is assigned to a participating CalOptima Health Provider and/or Health Network.
California Children's Services (CCS)-Eligible Condition	A medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 et seq.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Member.
CalOptima Health Direct (COHD) Member	A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network; and 3. Ability to function as a Primary Care Provider (PCP).
Covered Services	Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, this Contract, and APLs that are made the responsibility of Contractor pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS)

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For 2025

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Policy:	EE.1101
Title:	**Additions, Changes, and Terminations to CalOptima Health Provider Information**
Department:	Provider Data Operations
Section:	Provider Data Management Services
CEO Approval:	*/s/*
Effective Date:	11/01/1995
Revised Date:	07/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 20250904 BOD Review Only

I. PURPOSE

The purpose of this policy is to establish guidelines and procedures for adding, changing, and terminating a Provider belonging to CalOptima Health's ~~network~~Community Network (CHCN) and its contracted ~~networks~~Health Networks to support coordination of care, ensure network adequacy management ~~and~~, accuracy of primary care membership assignment, and the Provider Directories.

II. POLICY

A. CalOptima Health requires its Health Networks, Delegated Provider Groups, and Providers to be knowledgeable and ~~up-to-date~~current on state and federal Provider data requirements which they are ~~expected~~required to adhere to and implement.

B. CalOptima Health requires its Health Networks, Delegated Provider Groups, and Providers to promptly inform CalOptima Health of any data changes to maintain data accuracy and ensure Member's timely access to care.

a. Provider Additions must be submitted to CalOptima Health a minimum of thirty (30) calendar days advanced written notice.

b. Provider Changes must be submitted to CalOptima Health a minimum of thirty (30) calendar days advanced written notice.

c. Provider Terminations: Minimum of ninety (90) calendar days advanced written notice in accordance with CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

d. Provider's Panel Status: In accordance with California Health and Safety Code Section 1367.27, any change to a Provider's panel status is required to be reported to CalOptima Health within five (5) business days of the change.

C. Providers terminating in CHCN but remaining in CalOptima Health's Network through other affiliated Health Networks and delegated groups, will be required to maintain a CHCN contract as

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outlined in Section III.C.3.c. of this policy to ensure continuity of care for Members identified with certain diagnoses who cannot be enrolled with a Health Network, as defined in CalOptima Health Policy DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment.

~~C.~~D. CalOptima Health shall process and manage Provider data to support Provider directories requirements, Member access and availability, and network adequacy requirements.

III. PROCEDURE

A. Adding Provider Data

1. Submission Process

a. Shall be communicated to CalOptima Health a minimum of thirty (30) calendar days advanced written notice.

b. Complete the CalOptima Health Add, Change and Termination (ACT) form (Attachment A) (recommended) or an e-mail with applicable data.

2. Documentation Requirements

a. Include all the Provider's complete contractual and demographic data.

b. Include a signed W-9 form.

c. Submit Provider profile showing complete credentialing information.

d. Medi-Cal (Practitioner and/or Group) and Medicare (refer to application Providers below) enrollment requirements must be met.

e. Health Network contract front and signature pages, clearly showing contract effective date.

f. Facility Site Review (FSR) completion date (application to Primary Care Physicians).

B. Changing Provider Data

1. Submission Process

a. Shall be communicated to CalOptima Health a minimum of thirty (30) calendar days advanced written notice or earliest possible.

b. Complete the CalOptima Health Add, Change, and Termination (ACT) form (Attachment A) (recommended) or an e-mail with applicable data.

2. Documentation Requirements

a. Clearly state Provider's data change with effective date.

b. Include a signed W-9 form, if applicable.

c. Submit a Provider profile showing complete credentialing information, if due to an ownership change.

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i. Submit contract front and signature page, clearly showing effective date.

d. FSR completion date (applicable to Primary Care Physicians), if applicable.

C. Terminating Provider Data

1. Submission Process

a. Shall be communicated to CalOptima Health a minimum of ninety (90) calendar days advanced written notice in accordance with CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

b. Complete the CalOptima Health Add, Change and Termination (ACT) form (Attachment A) (recommended) or an e-mail with applicable data.

2. Documentation Requirements

a. Include a copy of the Provider termination notice with the effective date and reason for termination.

b. For a PCP who terminates from CHCN and requests to maintain the relationship with Member.

i. The Provider shall submit a written request to CalOptima Health's Provider Relations Department at least sixty (60) calendar days prior to the expected date of termination including the Health Network name for Member assignment as appropriate.

ii. must have an active affiliation and their panel status "open" with the selected Health Network the Members are being assigned to.

c. Health Networks must include transferring Provider information if the Provider being terminated is a PCP.

3. Termination Notifications

a. ~~For terminating Providers,~~ CalOptima Health or the Health Network shall review all requests for termination, identify impacted membership, programs and services to determine proper course of action.

~~a.~~b. CalOptima Health will notify ~~affected~~impacted Members and ~~DHCS~~regulators, as applicable, in accordance with CalOptima Health -Policies DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment, Policy DD.2008: Health Network Selection Process, Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services, Policy MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification, and Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

c. If a Primary Care Provider (PCP) requests to terminate its contract with CalOptima Health Care Network (CHCN) for Medi-Cal and transition Members to a different contracted Health Network, CalOptima Health shall require the PCP to maintain a CHCN contract to continue to provide Covered Services to CalOptima Health complex Members, in

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accordance with CalOptima Health Policy DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment. All other Medi-Cal Members will be transitioned, as requested, unless Members make other choice, and CHCN panels will be closed to non-complex Members.

d. If a specialist Provider requests to terminate its CHCN contract, CalOptima Health shall process the termination in accordance with applicable CalOptima Health Policies and the CHCN contract. Should the Provider wish to continue to service CalOptima Health Members post termination of the CHCN contract, the Provider shall be required to enter separate Letters of Agreement (LOA) with CalOptima Health.

~~b.~~c. The Provider Data Management Services (PDMS) Department shall notify its Customer Service department of Provider termination for the purpose of Member notification and re-assignment of Members.

~~c.~~f. Upon notification of a Provider change that impacts multiple networks such as a notice of Provider leaving the workforce (retirement or deceased) or office location closure, CalOptima Health shall update its system for all Networks and communicate to all Health Network the required changes.

i. Health Networks shall review and update their records to maintain consistency with Provider change notice.

ii. Health Networks shall confirm or dispute the changes within five (5) business days.

4. Upon receipt of complete and correct information, CalOptima Health's PDMS Department shall add, change or term a Health Network, Delegated Provider Group and/or Provider in the system of record within five (5) business days of submission based on the effective date indicated on the form.

5. All CalOptima Health Networks, Delegated Provider Groups, and Providers shall ensure Provider credentials, validations and enrollment requirements are accurate according to contract and applicable regulations. This includes validating Medi-Cal Enrollment, Medicare Enrollment, sanctions, active credentials, and other regulatory requirements as required per contractual agreements.

6. If discrepancies are identified, the PDMS department shall reject and return the request to the submitter for clarification within five (5) business days. Once the discrepancies are resolved, the corrected information must be resubmitted to the PDMS Department within five (5) business days.

7. The PDMS Department shall update the Provider file(s) in the system of record and, subsequently, the Web-based Directory, within five (5) business days of receipt of completed information.

~~D.~~E. Reporting

1. The PDMS department shall ensure Provider NPIs are validated on a monthly basis and Medi-Cal directory Providers are added to the Department of Healthcare Services' (DHCS) 274 Directory Network File.

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2. On a weekly basis, the PDMS Department shall send a summary report to each of its contracted Health Networks including its internal network (CHCN) of all the Provider Additions, Changes, and Terminations for review of accuracy.

   a. If discrepancies are identified on any Provider files, Health Networks and CHCN shall address the discrepancies.

      i. Upon addressing discrepancies, the Health Network or CHCN shall notify the PDMS Department.

      ii. The PDMS Department shall update the Provider file within five (5) business days in the system of record.

Table 1: Provider Data Required

Provider Elements	Type	Requirement
Legal Provider Name	Practitioner/Facility	Required
Program information (contracted CalOptima Health programs) and effective date	Practitioner/Facility	Required
Board certified specialty	Practitioner	If applicable
Taxonomy (primary, secondary, tertiary) (See Attachment C: NUCC Taxonomy Code List)	Practitioner/Facility	Required
Type 1 (individual) NPI	Practitioner	Required
Type 2 (organizations) NPI	Practitioner/Facility	If applicable
Tax identification number (TIN)	Practitioner/Facility	Required
State license number	Practitioner/Facility	Required
Gender	Practitioner	Required
Address, telephone and facsimile number for the Provider service location	Practitioner/Facility	Required
Telephone number for after normal business hours	Practitioner/Facility	If applicable
Days and hours of operation	Practitioner/Facility	Required
Hospital affiliation and privileges	Practitioner	Required
Accepting new patients	Practitioner	Required
Age limits (Member age minimum, Member age maximum, gender restrictions)	Practitioner	Required
Languages spoken by the physician including American Sign Language	Practitioner	Required
Languages spoken by clinical staff	Practitioner/Facility	Required
Telehealth Provider indicators: (Only Telehealth) (No Telehealth (only in-person) (Both telehealth and in-person)	Practitioner	Required
Telehealth Site indicators: (Only Telehealth) (No Telehealth (only in-person) (Both telehealth and in-person)	Practitioner/Facility	Required
Medi-Cal enrolled (Y/N) and effective date	Practitioner/Facility	Required
Medicare enrolled (Y/N) and enrollment id	Facility	If applicable

IV. ATTACHMENT(S)

A. CalOptima Health Add/Change/Term (ACT) form
B. ACT Form User Guide
C. National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy Code Set

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V. REFERENCE(S)

A. CalOptima Health Contract for Health Provider Care Services
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
F. CalOptima Health Policy DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment
G. CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process
H. CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services
I. CalOptima Health Policy GG.1608: Full Scope Site Reviews
J. CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
K. CalOptima Health Policy MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification
L. Health and Safety Code (HSC), §1367.27
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Supersedes APL 16-001)
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment (Supersedes APL 19-004) (Revised January 2, 2025)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031) (Revised November 3, 2023)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (Supersedes APL 09-009)
R. Medi-Cal Managed Care Division (MMCD) Policy Letter (PL) 00-002: Supersedes Policy Letter 97-09: Health Plan Provider Directory Policy, Guidelines, and Delivery Standards
S. Medi-Cal Managed Care Division (MMCD) Policy Letter (PL) 11-009: Update to Policy Letter 00-002: Update to Health Plan Provider Directory Policy and Guidelines
T. National Committee of Quality Assurance (NCQA) 2024 Health Plan (HP) Standards and Guidelines
U. NUCC Taxonomy Code List: https://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/pdf-mainmenu-53
V. Title 42, Code of Federal Regulations (CFR), § 438.10(h)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/17/2014	Department of Health Care Services (DHCS)	Approved As Submitted
01/26/2015	Department of Health Care Services (DHCS)	Approved As Submitted
07/06/2015	Department of Health Care Services (DHCS)	Approved As Submitted
07/26/2021	Department of Health Care Services (DHCS)	Approved As Submitted
05/02/2023	Department of Health Care Services (DHCS)	Approved As Submitted
07/03/2023	Department of Health Care Services (DHCS)	Approved As Submitted

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Date	Regulatory Agency	Response
06/13/2024	Department of Health Care Services (DHCS)	Approved As Submitted

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors
02/03/2022	Regular Meeting of the CalOptima Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1995	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	04/01/2004	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	07/01/2007	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2011	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	03/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	08/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2013	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2014	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	03/01/2015	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	03/15/2015	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	06/01/2015	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	07/01/2016	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	07/01/2017	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	03/07/2019	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	02/03/2022	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	01/01/2023	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	11/01/2023	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	05/01/2024	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	09/01/2024	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	12/05/2024	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2025	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information	Medi-Cal OneCare PACE
Revised	07/01/2025	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Additions	Term referred to in the Addition, Change, and Termination (ACT) process to add a Provider, Practitioner or Facility to the system of record. Health Networks are recommended to submit ACT forms and necessary documentation as outlined in this policy to add a Provider, Practitioner or Facility pursuant to the terms of the Agreement.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Changes	Term referred to in the Addition, Change, and Termination (ACT) process to make a demographic or other change a Provider, Practitioner or Facility in the system of record. Health Networks are recommended to submit ACT forms and necessary documentation as outlined in this policy to make demographic or other changes to the system of record pursuant to the terms of the Agreement.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services);

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Term	Definition
	4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county or State health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid

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Term	Definition
	Services (CMS) Contract, or Care Coordination or Coordination of Care as defined in the State Medicaid Agency Contract.
Delegated Provider Group	Health care entity with authority to credential its health care practitioners.
Doula	A birth worker who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, otherwise known as the perinatal period, for up to one year after pregnancy and provides support during miscarriage, stillbirth, and abortion (pregnancy termination) as set forth in DHCS APL 23-024: Doula Services.
Facility	For purposes of this policy, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.
Member	A beneficiary enrolled in a CalOptima Health program.
National Uniform Claim Committee (NUCC)	The official maintainer of the Health Care Provider Taxonomy code set. https://nucc.org/index.php/code-sets-mainmenu-41/Provider-taxonomy-mainmenu-40/pdf-mainmenu-53.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Provider	For purposes of this Policy, any individual, entity, Health Network, or Delegated Provider Group that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Telehealth	A method of delivering health care services by using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at a separate location from the Provider.
Terminations	Term referred to in the Addition, Change, and Termination (ACT) process to terminate a Provider, Practitioner or Facility from the system of record. Health Networks shall submit notification of termination pursuant to the terms of the Agreement.

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Policy:	EE.1101
Title:	**Additions, Changes, and Terminations to CalOptima Health Provider Information**
Department:	Provider Data Operations
Section:	Provider Data Management Services
CEO Approval:	*/s/*
Effective Date:	11/01/1995
Revised Date:	07/01/2025
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

The purpose of this policy is to establish guidelines and procedures for adding, changing, and terminating a Provider belonging to CalOptima Health's Community Network (CHCN) and its contracted Health Networks to support coordination of care, ensure network adequacy management, accuracy of primary care membership assignment, and the Provider Directories.

II. POLICY

A. CalOptima Health requires its Health Networks, Delegated Provider Groups, and Providers to be knowledgeable and current on state and federal Provider data requirements which they are required to adhere to and implement.

B. CalOptima Health requires its Health Networks, Delegated Provider Groups, and Providers to promptly inform CalOptima Health of any data changes to maintain data accuracy and ensure Member's timely access to care.

a. Provider Additions must be submitted to CalOptima Health a minimum of thirty (30) calendar days advanced written notice.

b. Provider Changes must be submitted to CalOptima Health a minimum of thirty (30) calendar days advanced written notice.

c. Provider Terminations: Minimum of ninety (90) calendar days advanced written notice in accordance with CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

d. Provider's Panel Status: In accordance with California Health and Safety Code Section 1367.27, any change to a Provider's panel status is required to be reported to CalOptima Health within five (5) business days of the change.

C. Providers terminating in CHCN but remaining in CalOptima Health's Network through other affiliated Health Networks and delegated groups, will be required to maintain a CHCN contract as outlined in Section III.C.3.c. of this policy to ensure continuity of care for Members identified with

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certain diagnoses who cannot be enrolled with a Health Network, as defined in CalOptima Health Policy DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment.

D. CalOptima Health shall process and manage Provider data to support Provider directories requirements, Member access and availability, and network adequacy requirements.

III. PROCEDURE

A. Adding Provider Data

1. Submission Process

a. Shall be communicated to CalOptima Health a minimum of thirty (30) calendar days advanced written notice.

b. Complete the CalOptima Health Add, Change and Termination (ACT) form (Attachment A) (recommended) or an e-mail with applicable data.

2. Documentation Requirements

a. Include all the Provider's complete contractual and demographic data.

b. Include a signed W-9 form.

c. Submit Provider profile showing complete credentialing information.

d. Medi-Cal (Practitioner and/or Group) and Medicare (refer to application Providers below) enrollment requirements must be met.

e. Health Network contract front and signature pages, clearly showing contract effective date.

f. Facility Site Review (FSR) completion date (application to Primary Care Physicians).

B. Changing Provider Data

1. Submission Process

a. Shall be communicated to CalOptima Health a minimum of thirty (30) calendar days advanced written notice or earliest possible.

b. Complete the CalOptima Health Add, Change, and Termination (ACT) form (Attachment A) (recommended) or an e-mail with applicable data.

2. Documentation Requirements

a. Clearly state Provider's data change with effective date.

b. Include a signed W-9 form, if applicable.

c. Submit a Provider profile showing complete credentialing information, if due to an ownership change.

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i. Submit contract front and signature page, clearly showing effective date.

d. FSR completion date (applicable to Primary Care Physicians), if applicable.

C. Terminating Provider Data

1. Submission Process

a. Shall be communicated to CalOptima Health a minimum of ninety (90) calendar days advanced written notice in accordance with CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

b. Complete the CalOptima Health Add, Change and Termination (ACT) form (Attachment A) (recommended) or an e-mail with applicable data.

2. Documentation Requirements

a. Include a copy of the Provider termination notice with the effective date and reason for termination.

b. For a PCP who terminates from CHCN and requests to maintain the relationship with Member.

i. The Provider shall submit a written request to CalOptima Health's Provider Relations Department at least sixty (60) calendar days prior to the expected date of termination including the Health Network name for Member assignment as appropriate.

ii. must have an active affiliation and their panel status "open" with the selected Health Network the Members are being assigned to.

c. Health Networks must include transferring Provider information if the Provider being terminated is a PCP.

3. Termination Notifications

a. CalOptima Health or the Health Network shall review all requests for termination, identify impacted membership, programs and services to determine proper course of action.

b. CalOptima Health will notify impacted Members and regulators, as applicable, in accordance with CalOptima Health Policies DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment, Policy DD.2008: Health Network Selection Process, Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services, Policy MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification, and Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

c. If a Primary Care Provider (PCP) requests to terminate its contract with CalOptima Health Care Network (CHCN) for Medi-Cal and transition Members to a different contracted Health Network, CalOptima Health shall require the PCP to maintain a CHCN contract to continue to provide Covered Services to CalOptima Health complex Members, in accordance with CalOptima Health Policy DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment. All other Medi-Cal

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Members will be transitioned, as requested, unless Members make other choice, and CHCN panels will be closed to non-complex Members.

d. If a specialist Provider requests to terminate its CHCN contract, CalOptima Health shall process the termination in accordance with applicable CalOptima Health Policies and the CHCN contract. Should the Provider wish to continue to service CalOptima Health Members post termination of the CHCN contract, the Provider shall be required to enter separate Letters of Agreement (LOA) with CalOptima Health.

e. The Provider Data Management Services (PDMS) Department shall notify its Customer Service department of Provider termination for the purpose of Member notification and re-assignment of Members.

f. Upon notification of a Provider change that impacts multiple networks such as a notice of Provider leaving the workforce (retirement or deceased) or office location closure, CalOptima Health shall update its system for all Networks and communicate to all Health Network the required changes.

i. Health Networks shall review and update their records to maintain consistency with Provider change notice.

ii. Health Networks shall confirm or dispute the changes within five (5) business days.

4. Upon receipt of complete and correct information, CalOptima Health's PDMS Department shall add, change or term a Health Network, Delegated Provider Group and/or Provider in the system of record within five (5) business days of submission based on the effective date indicated on the form.

5. All CalOptima Health Networks, Delegated Provider Groups, and Providers shall ensure Provider credentials, validations and enrollment requirements are accurate according to contract and applicable regulations. This includes validating Medi-Cal Enrollment, Medicare Enrollment, sanctions, active credentials, and other regulatory requirements as required per contractual agreements.

6. If discrepancies are identified, the PDMS department shall reject and return the request to the submitter for clarification within five (5) business days. Once the discrepancies are resolved, the corrected information must be resubmitted to the PDMS Department within five (5) business days.

7. The PDMS Department shall update the Provider file(s) in the system of record and, subsequently, the Web-based Directory, within five (5) business days of receipt of completed information.

E. Reporting

1. The PDMS department shall ensure Provider NPIs are validated on a monthly basis and Medi-Cal directory Providers are added to the Department of Healthcare Services' (DHCS) 274 Directory Network File.

2. On a weekly basis, the PDMS Department shall send a summary report to each of its contracted Health Networks including its internal network (CHCN) of all the Provider Additions, Changes, and Terminations for review of accuracy.

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a. If discrepancies are identified on any Provider files, Health Networks and CHCN shall address the discrepancies.

i. Upon addressing discrepancies, the Health Network or CHCN shall notify the PDMS Department.

ii. The PDMS Department shall update the Provider file within five (5) business days in the system of record.

Table 1: Provider Data Required

Provider Elements	Type	Requirement
Legal Provider Name	Practitioner/Facility	Required
Program information (contracted CalOptima Health programs) and effective date	Practitioner/Facility	Required
Board certified specialty	Practitioner	If applicable
Taxonomy (primary, secondary, tertiary) (See Attachment C: NUCC Taxonomy Code List)	Practitioner/Facility	Required
Type 1 (individual) NPI	Practitioner	Required
Type 2 (organizations) NPI	Practitioner/Facility	If applicable
Tax identification number (TIN)	Practitioner/Facility	Required
State license number	Practitioner/Facility	Required
Gender	Practitioner	Required
Address, telephone and facsimile number for the Provider service location	Practitioner/Facility	Required
Telephone number for after normal business hours	Practitioner/Facility	If applicable
Days and hours of operation	Practitioner/Facility	Required
Hospital affiliation and privileges	Practitioner	Required
Accepting new patients	Practitioner	Required
Age limits (Member age minimum, Member age maximum, gender restrictions)	Practitioner	Required
Languages spoken by the physician including American Sign Language	Practitioner	Required
Languages spoken by clinical staff	Practitioner/Facility	Required
Telehealth Provider indicators: (Only Telehealth) (No Telehealth (only in-person) (Both telehealth and in-person)	Practitioner	Required
Telehealth Site indicators: (Only Telehealth) (No Telehealth (only in-person) (Both telehealth and in-person)	Practitioner/Facility	Required
Medi-Cal enrolled (Y/N) and effective date	Practitioner/Facility	Required
Medicare enrolled (Y/N) and enrollment id	Facility	If applicable

IV. ATTACHMENT(S)

A. CalOptima Health Add/Change/Term (ACT) form
B. ACT Form User Guide
C. National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy Code Set

V. REFERENCE(S)

A. CalOptima Health Contract for Health Provider Care Services

For 20250904 BOD Review Only

B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
F. CalOptima Health Policy DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment
G. CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process
H. CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services
I. CalOptima Health Policy GG.1608: Full Scope Site Reviews
J. CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
K. CalOptima Health Policy MA.4010: Health Network and Primary Care Provider Selection, Assignment, and Notification
L. Health and Safety Code (HSC), §1367.27
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Supersedes APL 16-001)
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment (Supersedes APL 19-004) (Revised January 2, 2025)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031) (Revised November 3, 2023)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (Supersedes APL 09-009)
R. Medi-Cal Managed Care Division (MMCD) Policy Letter (PL) 00-002: Supersedes Policy Letter 97-09: Health Plan Provider Directory Policy, Guidelines, and Delivery Standards
S. Medi-Cal Managed Care Division (MMCD) Policy Letter (PL) 11-009: Update to Policy Letter 00-002: Update to Health Plan Provider Directory Policy and Guidelines
T. National Committee of Quality Assurance (NCQA) 2024 Health Plan (HP) Standards and Guidelines
U. NUCC Taxonomy Code List: https://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/pdf-mainmenu-53
V. Title 42, Code of Federal Regulations (CFR), § 438.10(h)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/17/2014	Department of Health Care Services (DHCS)	Approved As Submitted
01/26/2015	Department of Health Care Services (DHCS)	Approved As Submitted
07/06/2015	Department of Health Care Services (DHCS)	Approved As Submitted
07/26/2021	Department of Health Care Services (DHCS)	Approved As Submitted
05/02/2023	Department of Health Care Services (DHCS)	Approved As Submitted
07/03/2023	Department of Health Care Services (DHCS)	Approved As Submitted
06/13/2024	Department of Health Care Services (DHCS)	Approved As Submitted

VII. BOARD ACTION(S)

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Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors
02/03/2022	Regular Meeting of the CalOptima Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1995	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	04/01/2004	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	07/01/2007	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2011	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	03/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	08/01/2012	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2013	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	09/01/2014	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal
Revised	03/01/2015	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	03/15/2015	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	06/01/2015	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	07/01/2016	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	07/01/2017	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	03/07/2019	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	02/03/2022	EE.1101	Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	01/01/2023	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	11/01/2023	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	05/01/2024	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	09/01/2024	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	12/05/2024	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory	Medi-Cal OneCare PACE
Revised	04/01/2025	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information	Medi-Cal OneCare PACE
Revised	07/01/2025	EE.1101	Additions, Changes, and Terminations to CalOptima Health Provider Information	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Additions	Term referred to in the Addition, Change, and Termination (ACT) process to add a Provider, Practitioner or Facility to the system of record. Health Networks are recommended to submit ACT forms and necessary documentation as outlined in this policy to add a Provider, Practitioner or Facility pursuant to the terms of the Agreement.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Changes	Term referred to in the Addition, Change, and Termination (ACT) process to make a demographic or other change a Provider, Practitioner or Facility in the system of record. Health Networks are recommended to submit ACT forms and necessary documentation as outlined in this policy to make demographic or other changes to the system of record pursuant to the terms of the Agreement.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services);

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Term	Definition
	4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county or State health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid

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Term	Definition
	Services (CMS) Contract, or Care Coordination or Coordination of Care as defined in the State Medicaid Agency Contract.
Delegated Provider Group	Health care entity with authority to credential its health care practitioners.
Doula	A birth worker who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, otherwise known as the perinatal period, for up to one year after pregnancy and provides support during miscarriage, stillbirth, and abortion (pregnancy termination) as set forth in DHCS APL 23-024: Doula Services.
Facility	For purposes of this policy, general acute care hospitals, skilled nursing facilities, urgent care clinics, ambulatory surgery centers, inpatient hospice, residential care facilities, freestanding birth centers or alternative birthing centers, and inpatient rehabilitation facilities.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Letter of Agreement (LOA)	An agreement with a specific Provider regarding the provision of a specific Covered Service to a Member in the absence of a Contract for the provision of such Covered Service.
Member	A beneficiary enrolled in a CalOptima Health program.
National Uniform Claim Committee (NUCC)	The official maintainer of the Health Care Provider Taxonomy code set. https://nucc.org/index.php/code-sets-mainmenu-41/Provider-taxonomy-mainmenu-40/pdf-mainmenu-53.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Provider	For purposes of this Policy, any individual, entity, Health Network, or Delegated Provider Group that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Telehealth	A method of delivering health care services by using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at a separate location from the Provider.
Terminations	Term referred to in the Addition, Change, and Termination (ACT) process to terminate a Provider, Practitioner or Facility from the system of record. Health Networks shall submit notification of termination pursuant to the terms of the Agreement.

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Add, Change and Termination Form

It is recommended that this form be used to report any additions, changes and/or terminations to a provider's network affiliates.
If this form is being used, a separate form must be completed for each contracted provider being terminated or whose status is changing.

Health Network Name:

Program (Check all that apply): ☐ **Medi-Cal** ☐ **OneCare** ☐ **PACE**

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)	(Middle Initial)	
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME	PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE / ZIP
REMIT ADDRESS		CITY	STATE / ZIP
OFFICE MANAGER	PHONE	FAX	PUBLIC EMAIL ADDRESS
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CPSP	

HOSPITAL/FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES		
1. _____	2. _____	3. _____
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF
☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT
☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL
☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL
☐ SUSPENDED	☐ SUSPENDED	☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ NEW ADD OR AFFILIATION

REQUIREMENTS: The Provider Relations (PR) representative must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by Provider Data Management Services (PDMS) and returned to the PR representative.

Effective Date **(required)**:	Date Credentialing Completed (within the last three years)	Current Facility Site Review Date (within the last three years)
PROVIDER TYPE	☐ **ANCILLARY/ALLIED HEALTH** ☐ **PCP** ☐ **SPECIALIST** ☐ **ECM** ☐ **COMMUNITY SUPPORTS**	☐ **Open Panel** ☐ **Closed Panel** ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ CHANGE IN PANEL STATUS

REQUIREMENTS: Panel changes are effective the date of processing.

PROVIDER TYPE (If applicable, check both)	
☐ **PCP** ☐ **SPECIALIST** ☐ **ECM** ☐ **COMMUNITY SUPPORTS**	☐ **Open Panel** ☐ **Closed Panel** ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ TAX ID CHANGE

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax ID (required):	Previous Tax ID	New Tax ID

^Optional to answer and not required

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ACTION REQUIREMENTS (cont.) (Check all that apply)

☐ TERMINATION

REQUIREMENTS: Complete this form for each provider being terminated from its provider network affiliates. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by PDMS and returned to the PR representative.

Effective date (required):	☐ **PCP** ☐ **SPECIALIST** ☐ **ANCILLARY**

Date CalOptima Health received the termination notice:

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider retired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider deceased
- ☐ Provider unwilling to accept member/payment terms
- ☐ Termed due to review action

PCP Termination: Assign member to new PCP: _____
Name of new PCP

Number of members impacted (as of date received): ☐ **Medi-Cal** _____ ☐ **OneCare** _____

Date member notice was mailed (if member notice has not been sent, please put anticipated date and notify CalOptima Health if date changes):

Number of days' notice provider gave to MCP:

☐ ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a facility site review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-Person		
Address		City	State	ZIP
Phone	Fax	Office Hours	After Hours Phone	
Office Manager		Email Address		

SERVICE ADDRESS **Check one: [ ] ADD [ ] TERM**	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
Address		City	State	Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number	
Office Manager		Email Address		

☐ LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages spoken by Provider, if fluent with communicating about medical care, put an asterisk next to the language (^ Language fluency is optional to disclose and not required)

1. _____ 2. _____ 3. _____

4. _____ 5 _____ 6. _____

Language services, such as American Sign Language (ASL), and interpreter services
Check all that apply

- ☐ In-office ASL interpreter
- ☐ In-office medical interpreter
- ☐ Other type of in-office interpreter service, fill in here _____

☐ Race/Ethnicity

^ Race/ethnicity of provider. Check all that apply:

- ☐ American Indian Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Choose not to share

☐ Gender-Affirming Care

^ Gender-Affirming Care services that the provider offers. Check all that apply:

- ☐ Voice Therapy
- ☐ Behavioral Health
- ☐ Endocrinology
- ☐ Pediatric Endocrinology
- ☐ Primary Care
- ☐ Hormone Replacement Therapy
- ☐ Electrolysis
- ☐ Laser
- ☐ Adolescent Medicine
- ☐ Voice Surgery
- ☐ Facial Surgery
- ☐ Body Contouring
- ☐ Plastic Surgery
- ☐ Bottom Gynecologist
- ☐ Bottom Reconstruct Urology
- ☐ Surgery Urology
- ☐ Top Surgery
- ☐ Dermatology

Consent to display "Gender-Affirming Care" in the Provider Directory ☐ **YES** ☐ **NO**

^Optional to answer and not required

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☐ **OTHER**	**Comments:**
PROVIDER RELATIONS REPRESENTATIVE (Please print)	
PROVIDER NAME (Please print)	
SIGNATURE	DATE

^Optional to answer and not required

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CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

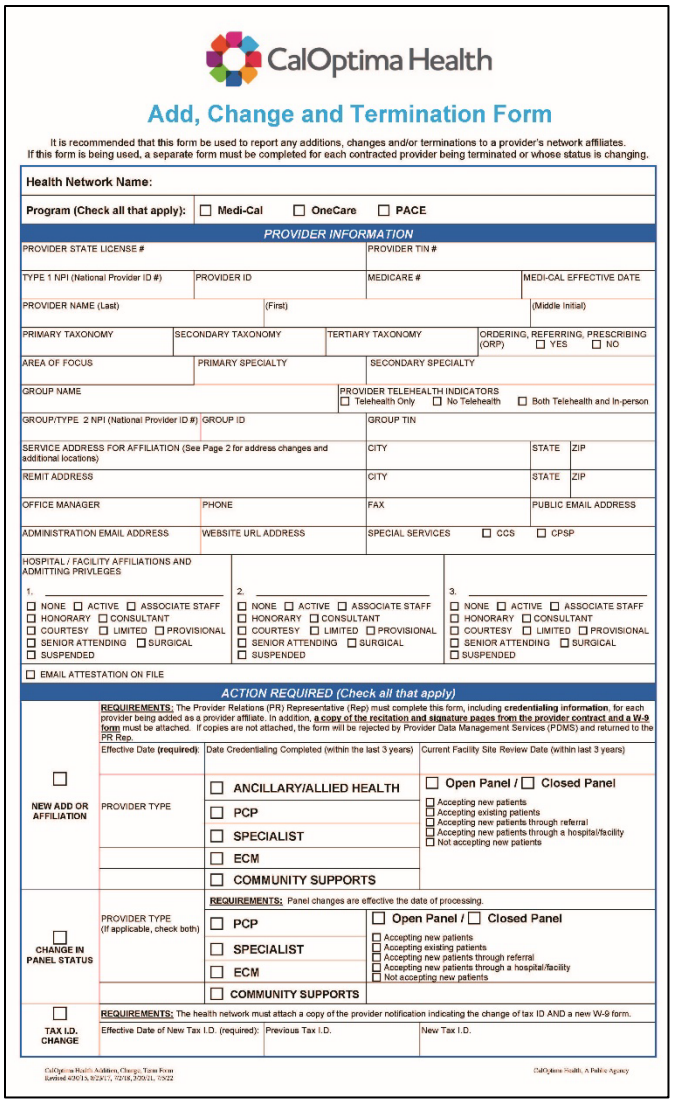
REQUIREMENTS

CalOptima Health requires its health networks (HN), subdelegates, providers and practitioners to promptly inform us of any changes to information regarding practitioner:

- **Demographics**
- **Credentialing**
- **Panel status —** including accepting new patients, accepting existing patients, accepting through a referral, accepting through a facility or hospital, and not accepting new patients
- **Other information requested in this file**

HEALTH NETWORKS

All HNs and subdelegates shall promptly, but no later than five business days from a change in the practitioner's panel status, inform CalOptima Health of such change. The HN, on a quarterly basis, verifies and updates the practitioner's information. The HN verification process includes a methodology to audit and confirm that the information provided by its practitioners is true and correct. HN maintains records of such verifications and shall provide them during the second and fourth quarters of the year.



CalOptima Health

Add, Change and Termination Form

It is recommended that this form be used to report any additions, changes and/or terminations to a provider's network affiliates.
If this form is being used, a separate form must be completed for each contracted provider being terminated or whose status is changing.

Health Network Name:

Program (Check all that apply): ☐ Medi-Cal ☐ OneCare ☐ PACE

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)		(Middle Initial)
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME		PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person	
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE ZIP
REMIT ADDRESS		CITY	STATE ZIP
OFFICE MANAGER	PHONE	FAX	PUBLIC EMAIL ADDRESS
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CPSP	

HOSPITAL / FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES

1.	2.	3.
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ **NEW ADD OR AFFILIATION**

REQUIREMENTS: The Provider Relations (PR) Representative (Rep) must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by Provider Data Management Services (PDMS) and returned to the PR Rep.

Effective Date (required):	Date Credentialing Completed (within the last 3 years)	Current Facility Site Review Date (within last 3 years)
PROVIDER TYPE	☐ ANCILLARY/ALLIED HEALTH ☐ PCP ☐ SPECIALIST ☐ ECM ☐ COMMUNITY SUPPORTS	☐ Open Panel / ☐ Closed Panel ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ **CHANGE IN PANEL STATUS**

REQUIREMENTS: Panel changes are effective the date of processing.

PROVIDER TYPE (If applicable, check both)	
☐ PCP ☐ SPECIALIST ☐ ECM ☐ COMMUNITY SUPPORTS	☐ Open Panel / ☐ Closed Panel ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ **TAX I.D. CHANGE**

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax I.D. (required):	Previous Tax I.D.	New Tax I.D.

CalOptima Health Addition, Change, Term Form
Revised 4/30/15, 8/24/17, 02/16, 3/20/21, 05/22

CalOptima Health, A Public Agency

ACT FORM INSTRUCTIONS

Please read through these instructions carefully, which specify the exact data content and data format of each column on the roster.

1) Do not change column name, column order, data format and do not add in new columns.
2) Any column left "blank" or null shall be rejected by the health plan.
3) Submit any practitioner (i.e. PCP, specialist, mid-level) participating within your CalOptima Health network.
4) Submit any practice location (medical office, clinic, etc.) participating within you CalOptima Health network.
5) Submit any hospital that provides health care services to CalOptima Health members within your network, regardless of CalOptima Health contractual relationship.
6) Submit any ancillary facility and its affiliated practitioners that provides health care services to CalOptima Health members within your network, regardless of CalOptima Health contractual relationship.
7) All provider types (taxonomy and specialty):
   a. Must be credentialed
   b. Only the taxonomy and specialty that are contracted at the location
   c. Please refer to the taxonomy codes submitted on the sFTP for taxonomy code table
8) Practice locations must pass Facility Site Review (FSR) - Physician and mid-level.
9) ACT Form submissions that deviate from the criteria listed above will be REJECTED and returned.
10) E-mail completed ACT form and required support documents to ProviderOnline@caloptima.org.

CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

HOW TO SUBMIT CALOPTIMA HEALTH ACT FORM

1) Complete all relevant sections of the CalOptima Health ACT Form
2) Attach a competed and signed W9
3) Include a copy of the front of your HN contract and signature page or CCN/COD Contract Summary
4) Complete a provider profile that includes the information listed below
5) E-mail completed ACT form and required support documents to ProviderOnline@caloptima.org
6) For questions and more information, call the CalOptima Health Provider Relations department at **714-246-8600**

Scope of Provider Type

1) **Physician** (individual)
   - Medical Doctor (M.D.)
   - Doctor of Osteopathic Medicine (D.O.)
   - Doctor of Podiatric Medicine (D.P.M.)

(2) **Mid-level** (individual)
   - Certified Nurse Practitioners (CNP)
   - Certified Nurse Midwifes (CNM)
   - Physician Assistants (PA)

(3) **Hospital**: Any hospital within the HN network, regardless of CalOptima Health's contractual relationship. Samples include, but are not limited to the following:

- Ambulatory surgery center
- Hospital with acute care
- Psychiatry hospital

(4) **Ancillary**: Any facility that provides health care services to CalOptima Health members within the HN, regardless of CalOptima Health-contractual relationship. Examples include but are not limited to the following:

- Adult day health care center/community base adult service
- Audiology
- Durable Medical Equipment
- End-stage renal disease provider/dialysis unit/hemodialysis
- Home health
- Home infusion
- Hospice
- Clinical laboratory
- Long-term services and supports
- Occupational therapy
- Physical therapy
- Portable X-ray supplier
- Radiology center
- Rehabilitation center
- Skilled nursing facility
- Transportation services
- Urgent care

… and others

Practitioner Practices at Ancillary (individual) – examples include are but not limited to the following:

- Acupuncturist
- Audiologist
- Chiropractor
- Physical therapist
- Radiation therapist
- Occupational therapist
- Speech therapist

… and others

CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

WHEN SHOULD I SUBMIT AN ACT REQUEST?

Additions: Term referred to in the ACT process to add a provider, practitioner or facility to CalOptima Health's system. HNs and subdelegates shall submit ACT forms and required documentation as outlined in this policy when adding a provider, practitioner or facility pursuant to the terms of the agreement. To add an additional location to an existing provider, please check the additional location box on Page 2 of the ACT form.

Changes: Term referred to in the ACT process to make a demographic or other change to a provider, practitioner or facility in CalOptima Health's system. HNs and subdelegates shall submit ACT forms and required documentation as outlined in this policy when making demographic or other changes to the CalOptima Health system pursuant to the terms of the agreement.

Terminations: Term referred to in the ACT process when terminating a provider, practitioner or facility from CalOptima Health's system. HNs and subdelegates shall submit notification of terminations pursuant to the terms of the agreement.

ADDITIONAL SUBMISSION REQUIREMENTS

Additions: When making an addition request, the group name, National Provider Identifier (NPI) and Tax Identification Number (TIN) must all correspond. In the event your submission consists of non-corresponding identifiers, it will not be honored.

Terminations: When requesting a termination of a provider's TIN, you must submit the group NPI along with the TIN.

Health Networks and Subdelegates

- Health networks and providers must take the following steps when requesting to move a provider from one group NPI to another group NPI:
    1. Submit ACT Termination form to remove the provider from the CalOptima Health system
    2. Submit ACT Addition form and required documentation as outlined in EE.1101 to add the provider to the CalOptima Health system with the new group NPI

    Note: Each of the above steps must be done separately.
- If you are adding or changing the address of a primary care provider (PCP), you must include the date of request along with a Facility Site Review (FSR) completion form with your submission request.

E-mail completed ACT form and required support documents to ProviderOnline@caloptima.org

Disclaimer – CalOptima Health will limit the registration of office locations outside of Orange County to only those that are addressing network adequacy and member access gaps unless indicated otherwise within the contract.

CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

Sample Addition

CalOptima Health

Add, Change and Termination Form

It is recommended that this form be used to report any additions, changes and/or terminations to a provider's network affiliates.
If this form is being used, a separate form must be completed for each contracted provider being terminated or whose status is changing.

Health Network Name:

Program (Check all that apply): ☐ Medi-Cal ☐ OneCare ☐ PACE

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)		(Middle Initial)
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME	PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
GROUP TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)	CITY	STATE	ZIP
REMIT ADDRESS	CITY	STATE	ZIP
OFFICE MANAGER	PHONE	FAX	PUBLIC EMAIL ADDRESS
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CPSP	

HOSPITAL/FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES

1. _____	2. _____	3. _____
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF
☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT
☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL
☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL
☐ SUSPENDED	☐ SUSPENDED	☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ **NEW ADD OR AFFILIATION**

REQUIREMENTS: The Provider Relations (PR) representative must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by Provider Data Management Services (PDMS) and returned to the PR representative.

Effective Date (required)	Date Credentialing Completed (within the last three years)	Current Facility Site Review Date (within the last three years)

PROVIDER TYPE

- ☐ ANCILLARY/ALLIED HEALTH
- ☐ PCP
- ☐ SPECIALIST
- ☐ ECM
- ☐ COMMUNITY SUPPORTS

☐ Open Panel ☐ Closed Panel

- ☐ Accepting new patients
- ☐ Accepting existing patients
- ☐ Accepting new patients through referral
- ☐ Accepting new patients through a hospital/facility
- ☐ Not accepting new patients

☐ **CHANGE IN PANEL STATUS**

REQUIREMENTS: Panel changes are effective the date of processing.

PROVIDER TYPE (If applicable, check both)

- ☐ PCP
- ☐ SPECIALIST
- ☐ ECM
- ☐ COMMUNITY SUPPORTS

☐ Open Panel ☐ Closed Panel

- ☐ Accepting new patients
- ☐ Accepting existing patients
- ☐ Accepting new patients through referral
- ☐ Accepting new patients through a hospital/facility
- ☐ Not accepting new patients

☐ **TAX ID CHANGE**

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax ID (required)	Previous Tax ID	New Tax ID

CalOptima Health Addition, Change, Term Form
Revised 03/18, 8/18AT, 10/18, 05/20, 7/20, 9/21

CalOptima Health, A Public Agency

^Optional to answer and not required

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ADD, CHANGE AND TERMINATION (ACT) FORM

ACTION REQUIREMENTS (cont.) (Check all that apply)

☐ TERMINATION

REQUIREMENTS: Complete this form for each provider being terminated from its provider network affiliation. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by PDMS and returned to the PR representative.

Effective date (required): ☐ PCP ☐ SPECIALIST ☐ ANCILLARY

Date CalOptima Health received the termination notice:

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider retired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider deceased
- ☐ Provider unwilling to accept member/payment terms
- ☐ Termed due to review action

PCP Termination: Assign member to new PCP: _____
Name of new PCP

Number of members impacted (as of date received): ☐ **Medi-Cal** _____ ☐ **OneCare** _____

Date member notice was mailed (if member notice has not been sent, please put anticipated date and notify CalOptima Health if date changes):

Number of days' notice provider gave to MCP:

☐ ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a facility site review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS Check one: [ ] ADD [ ] TERM	Effective Date (required):	SITE TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-Person	
Address:		City	State / ZIP
Phone	Fax	Office Hours	After Hours Phone
Office Manager		Email Address	

SERVICE ADDRESS Check one: [ ] ADD [ ] TERM	Effective Date (required):	SITE TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person	
Address:		City	State / Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number
Office Manager		Email Address	

☐ LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages spoken by Provider, if fluent with communicating about medical care, put an asterisk next to the language (* Language fluency is optional to disclose and not required)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Language services, such as American Sign Language (ASL), and interpreter services
Check all that apply:

- ☐ In-office ASL interpreter
- ☐ In-office medical interpreter
- ☐ Other type of in-office interpreter service, fill in here _____

☐ Race/Ethnicity

^ Race/ethnicity of provider. Check all that apply:

- ☐ American Indian Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Choose not to share

☐ OTHER

Comments:

PROVIDER RELATIONS REPRESENTATIVE
(Please print)

PROVIDER NAME
(Please print)

SIGNATURE	DATE

^Optional to answer and not required

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ADD, CHANGE AND TERMINATION (ACT) FORM

Sample Change

CalOptima Health

Add, Change and Termination Form

It is recommended that this form be used to report any additions, changes and/or terminations to a provider's network affiliates.
If this form is being used, a separate form must be completed for each contracted provider being terminated or whose status is changing.

Health Network Name:

Program (Check all that apply): ☐ Medi-Cal ☐ OneCare ☐ PACE

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)		(Middle Initial)
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME	PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE ZIP
REMIT ADDRESS		CITY	STATE ZIP
OFFICE MANAGER	PHONE	FAX	PUBLIC EMAIL ADDRESS
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ DDS ☐ CPSP	

HOSPITAL/FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES

1. _____	2. _____	3. _____
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF
☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT	☐ HONORARY ☐ CONSULTANT
☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL	☐ COURTESY ☐ LIMITED ☐ PROVISIONAL
☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL	☐ SENIOR ATTENDING ☐ SURGICAL
☐ SUSPENDED	☐ SUSPENDED	☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ NEW ADD OR AFFILIATION

REQUIREMENTS: The Provider Relations (PR) representative must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, **a copy of the recitation and signature pages from the provider contract and a W-9 form** must be attached. If copies are not attached, the form will be rejected by Provider Data Management Services (PDMS) and returned to the PR representative.

Effective Date (required):	Date Credentialing Completed (within the last three years)	Current Facility Site Review Date (within the last three years)
PROVIDER TYPE	☐ ANCILLARY/ALLIED HEALTH ☐ PCP ☐ SPECIALIST ☐ ECM ☐ COMMUNITY SUPPORTS	☐ Open Panel ☐ Closed Panel ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ CHANGE IN PANEL STATUS

REQUIREMENTS: Panel changes are effective the date of processing.

PROVIDER TYPE (If applicable, check both)		
	☐ PCP ☐ SPECIALIST ☐ ECM ☐ COMMUNITY SUPPORTS	☐ Open Panel ☐ Closed Panel ☐ Accepting new patients ☐ Accepting existing patients ☐ Accepting new patients through referral ☐ Accepting new patients through a hospital/facility ☐ Not accepting new patients

☐ TAX ID CHANGE

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax ID (required):	Previous Tax ID	New Tax ID

CalOptima Health Addition, Change, Term Form
Revised 03/18, 8/2017, 10/18, 1/2020, 7/2020, 9/2021

CalOptima Health, A Public Agency

^Optional to answer and not required

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ADD, CHANGE AND TERMINATION (ACT) FORM

ACTION REQUIREMENTS (cont.) (Check all that apply)

☐ TERMINATION

REQUIREMENTS: Complete this form for each provider being terminated from its provider network affiliations. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by POMS and returned to the PR representative.

Effective date (required):	☐ PCP ☐ SPECIALIST ☐ ANCILLARY
Date CalOptima Health received the termination notice:	

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider retired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider deceased
- ☐ Provider unwilling to accept member/payment terms
- ☐ Termed due to review action

PCP Termination: Assign member to new PCP: _____
Name of new PCP

Number of members impacted (as of date received): ☐ **Medi-Cal** _____ ☐ **OneCare** _____

Date member notice was mailed (if member notice has not been sent, please put anticipated date and notify CalOptima Health if date changes):

Number of days' notice provider gave to MCP:

☐ ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a facility site review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS Check one: [ ] ADD [ ] TERM	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-Person		
Address:		City	State	ZIP
Phone	Fax	Office Hours	After Hours Phone	
Office Manager		Email Address		

SERVICE ADDRESS Check one: [ ] ADD [ ] TERM	Effective Date (required):	SITE TELEHEATH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
Address:		City	State	Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number	
Office Manager		Email Address		

☐ LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages spoken by Provider, if fluent with communicating about medical care, put an asterisk next to the language (* Language fluency is optional to disclose and not required)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Language services, such as American Sign Language (ASL), and interpreter services
Check all that apply

- ☐ In-office ASL interpreter
- ☐ In-office medical interpreter
- ☐ Other type of in-office interpreter service, fill in here _____

☐ Race/Ethnicity

^ Race/ethnicity of provider. Check all that apply:

- ☐ American Indian Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Choose not to share

☐ OTHER

Comments:

PROVIDER RELATIONS REPRESENTATIVE
(Please print)

PROVIDER NAME
(Please print)

SIGNATURE	DATE

^Optional to answer, but encouraged

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ADD, CHANGE AND TERMINATION (ACT) FORM

Sample Termination

CalOptima Health

Add, Change and Termination Form

It is recommended that this form be used to report any additions, changes and/or terminations to a provider's network affiliates.
If this form is being used, a separate form must be completed for each contracted provider being terminated or whose status is changing.

Health Network Name:

Program (Check all that apply): ☐ Medi-Cal ☐ OneCare ☐ PACE

PROVIDER INFORMATION

PROVIDER STATE LICENSE #		PROVIDER TIN #	
TYPE 1 NPI (National Provider ID #)	PROVIDER ID	MEDICARE #	MEDI-CAL EFFECTIVE DATE
PROVIDER NAME (Last)	(First)		(Middle Initial)
PRIMARY TAXONOMY	SECONDARY TAXONOMY	TERTIARY TAXONOMY	ORDERING, REFERRING, PRESCRIBING (ORP) ☐ YES ☐ NO
AREA OF FOCUS	PRIMARY SPECIALTY	SECONDARY SPECIALTY	
GROUP NAME	PROVIDER TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
GROUP/TYPE 2 NPI (National Provider ID #)	GROUP ID	GROUP TIN	
SERVICE ADDRESS FOR AFFILIATION (See Page 2 for address changes and additional locations)		CITY	STATE ZIP
REMIT ADDRESS		CITY	STATE ZIP
OFFICE MANAGER	PHONE	FAX	PUBLIC EMAIL ADDRESS
ADMINISTRATION EMAIL ADDRESS	WEBSITE URL ADDRESS	SPECIAL SERVICES ☐ CCS ☐ CPSP	

HOSPITAL/FACILITY AFFILIATIONS AND ADMITTING PRIVILEGES

1.	2.	3.
☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED	☐ NONE ☐ ACTIVE ☐ ASSOCIATE STAFF ☐ HONORARY ☐ CONSULTANT ☐ COURTESY ☐ LIMITED ☐ PROVISIONAL ☐ SENIOR ATTENDING ☐ SURGICAL ☐ SUSPENDED

☐ EMAIL ATTESTATION ON FILE

ACTION REQUIRED (Check all that apply)

☐ **NEW ADD OR AFFILIATION**

REQUIREMENTS: The Provider Relations (PR) representative must complete this form, including **credentialing information**, for each provider being added as a provider affiliate. In addition, a copy of the recitation and signature pages from the provider contract and a W-9 form must be attached. If copies are not attached, the form will be rejected by Provider Data Management Services (PDMS) and returned to the PR representative.

Effective Date (required):	Date Credentialing Completed (within the last three years)	Current Facility Site Review Date (within the last three years)

PROVIDER TYPE

- ☐ ANCILLARY/ALLIED HEALTH
- ☐ PCP
- ☐ SPECIALIST
- ☐ ECM
- ☐ COMMUNITY SUPPORTS

☐ Open Panel ☐ Closed Panel

- ☐ Accepting new patients
- ☐ Accepting existing patients
- ☐ Accepting new patients through referral
- ☐ Accepting new patients through a hospital/facility
- ☐ Not accepting new patients

☐ **CHANGE IN PANEL STATUS**

REQUIREMENTS: Panel changes are effective the date of processing.

PROVIDER TYPE (If applicable, check both)

- ☐ PCP
- ☐ SPECIALIST
- ☐ ECM
- ☐ COMMUNITY SUPPORTS

☐ Open Panel ☐ Closed Panel

- ☐ Accepting new patients
- ☐ Accepting existing patients
- ☐ Accepting new patients through referral
- ☐ Accepting new patients through a hospital/facility
- ☐ Not accepting new patients

☐ **TAX ID CHANGE**

REQUIREMENTS: The health network must attach a copy of the provider notification indicating the change of tax ID AND a new W-9 form.

Effective Date of New Tax ID (required):	Previous Tax ID	New Tax ID

CalOptima Health Addition, Change, Term Form
Revised 03/15, 8/15/17, 10/16, 1/2020, 7/2020, 04/2021

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^Optional to answer and not required

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ADD, CHANGE AND TERMINATION (ACT) FORM

ACTION REQUIREMENTS (cont.) (Check all that apply)

☐ TERMINATION

REQUIREMENTS: Complete this form for each provider being terminated from its provider network/ affiliation. If the termination is requested by the provider, a copy of the request from the provider must be attached. If a copy is not attached, the form will be rejected by PDMS and returned to the PR representative.

Effective date (required): ☐ PCP ☐ SPECIALIST ☐ ANCILLARY

Date CalOptima Health received the termination notice:

Exceptions: Review found that the termed specialist is exempt from providing continued access based on the exemption checked below.

- ☐ Provider not available
- ☐ Provider retired
- ☐ Contract not continued
- ☐ Other: _____
- ☐ Provider deceased
- ☐ Provider unwilling to accept member/payment terms
- ☐ Termed due to review action

PCP Termination: Assign member to new PCP: _____
Name of new PCP

Number of members impacted (as of date received): ☐ Medi-Cal _____ ☐ OneCare _____

Date member notice was mailed (if member notice has not been sent, please put anticipated date and notify CalOptima Health if date changes):

Number of days' notice provider gave to MCP:

☐ ADDRESS/PHONE CHANGE OR ADDITIONAL LOCATION

REQUIREMENTS: For all address changes, select [TERM] to remove an old/prior address and select [ADD] to add the new location. For additional location, select [ADD] to add the additional location. If PCP site, a facility site review is required. A copy of documentation submitted by the provider AND a new W-9 form must be attached, if applicable. Note: The form contains three address sections, allowing multiple changes to be entered for one provider on the same form.

SERVICE ADDRESS Check one: [ ] ADD [ ] TERM	Effective Date (required)	SITE TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-Person		
Address		City	State	ZIP
Phone	Fax	Office Hours	After Hours Phone	
Office Manager		Email Address		

SERVICE ADDRESS Check one: [ ] ADD [ ] TERM	Effective Date (required)	SITE TELEHEALTH INDICATORS ☐ Telehealth Only ☐ No Telehealth ☐ Both Telehealth and In-person		
Address		City	State	Zip
Phone Number	Fax Number	Office Hours	After Hours Phone Number	
Office Manager		Email Address		

☐ LANGUAGE

Languages Spoken by Staff

1. _____ 2. _____ 3. _____

Languages spoken by Provider, if fluent with communicating about medical care, put an asterisk next to the language (* Language fluency is optional to disclose and not required)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Language services, such as American Sign Language (ASL) and interpreter services
Check all that apply:

- ☐ In-office ASL interpreter
- ☐ In-office medical interpreter
- ☐ Other type of in-office interpreter service, fill in here _____

☐ Race/Ethnicity

^ Race/ethnicity of provider. Check all that apply:

- ☐ American Indian Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Choose not to share

☐ OTHER

Comments:

PROVIDER RELATIONS REPRESENTATIVE
(Please print)

PROVIDER NAME
(Please print)

SIGNATURE	DATE

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^Optional to answer and not required

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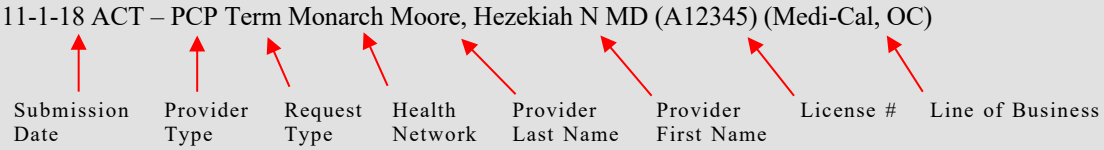
ADDENDUM

CalOptima Health requests use of the email header naming convention reflected below to ensure compliance with turnaround guidelines. Please use the headers below; do not add "Urgent" or deviate from the headers below.

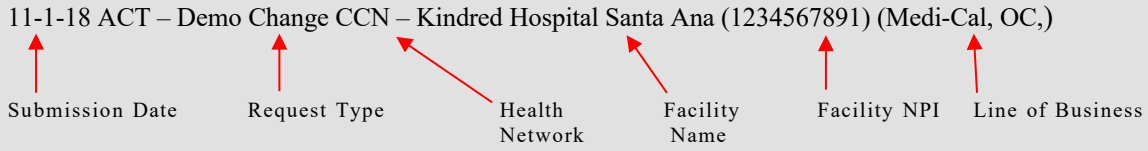
Naming Convention for Email Subject Headers

Provider



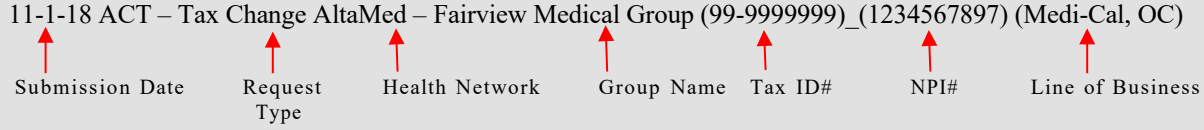
Provider email subject header naming convention:
Submission Date: Date form is submitted
Provider Type: PCP, SPC, MIDLEVEL, ANC
Request Type: Add, Change, Term, CAP (Corrective Action Plan)
Health Network Name: Provider health network affiliation
Provider Last Name: Last name of provider based on state license
Provider First Name: First name of provider based on state license
License #: State license number
Line of Business: MC = Medi-Cal, OC = OneCare

Facility



Facility email subject header naming convention:
Submission Date: Date form is submitted
Request Type: Add, Change, Term, CAP (Corrective Action Plan)
Health Network Name: Facility health network affiliation Facility
Name: Facility name as reflected on agreement
Facility NPI: Facility NPI
Line of Business: MC = Medi-Cal, OC = OneCare

Group



Group Email Subject Header Naming Convention:
Submission Date: Date form is submitted
Request Type: Add, Change, Term, CAP (Corrective Action Plan)
Health Network Name: Provider's health network affiliation
Group Name: Name of group as reflected on agreement
Tax-ID: Group Tax ID on accompanying W-9
NPI #: Type 2 NPI

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CalOptima Health User Guide

ADD, CHANGE AND TERMINATION (ACT) FORM

DEFINITIONS

HEALTH NETWORK NAME	Health network group name
LINE OF BUSINESS	The program/product code the practitioner affiliates with CalOptima Health at the practice location. Lines of business codes include: MC = Medi-Cal; OC = OneCare; PACE = PACE. If practitioner has more than one program, insert additional line of business records (rows) for each program.
CA LICENSE NUMBER	California license number of the practitioner. Catenate the license type letter (NP, CNM and PA for mid-level; A, C, G, and 20A for MD and DO; E for DPM) and license number together and no space in between.
PROVIDER TIN	The individual federal tax ID of the practitioner. Note: It is NOT a provider group, IPA or location's TIN. Numbers only - no space and no special characters.
TYPE 1 NPI	National provider identifier of the practitioner (NPI type 1, 10 digits).
PROVIDER ID	The individual identification number assigned by CalOptima to be used for existing providers for demographic changes and terminations (9 digits = solo practitioner; 12 digits = affiliated to a group).
MEDICARE NUMBER	CMS Certification Number is used to verify that a provider has been Medicare-/Medicaid-certified and for what type of services. Formerly it was known as 1) OSCAR provider number 2) Medicare Identification Number or 3) Medicare/Medicaid Identification Number. Reference: CMS Manual System, Pub 100-07 State Operations Provider Certification.
MEDI-CAL EFFECTIVE DATE	Effective date the provider received a Medicaid provider number.
PROVIDER LAST NAME	Full last name attached to the practitioner's professional license issued by the State of California. For practitioners not subject to state licensure, such as certain qualified autism service providers, it means the last name appearing on the certification by a national entity.
PROVIDER FIRST NAME	Full first name attached to the practitioner's professional license issued by the State of California. For practitioners not subject to state licensure, such as certain qualified autism service providers, it means the first name appearing on the certification by a national entity.
PROVIDER MIDDLE NAME	Full middle name attached to the practitioner's professional license issued by the State of California. For practitioners not subject to state licensure, such as certain qualified autism service providers, it means the middle name appearing on the certification by a national entity.
TAXONOMY (PRIMARY, SECONDARY, TERTIARY)	The taxonomy code of the specialty for which the practitioner has. Please refer to the taxonomy crosswalk provided by CalOptima Health.
FACILITY PHYSICAL ACCESSIBILITY COMPLIANCE	Meets facility American Disability Act (ADA) handicapped compliance.
ORDERING, REFERRING, PRESCRIBING (ORP)	State or federal regulated certification for providers who order, refer or prescribe.
AREA OF FOCUS	The specific focus of the practitioner's specialty.
PRIMARY SPECIALTY	The primary specialty for which the practitioner is contracted to provide services at the location. When providers practice at multiple sites, they may have different primary and secondary specialties for each site based on the contract.

SECONDARY SPECIALTY	The secondary specialty for which the practitioner is contracted to provide services at the location. When providers practice at multiple sites, they may have different primary and secondary specialties for each site based on the contract.
GROUP NAME	Full name of Medical Group practitioner is affiliated with based on contract.
GROUP/TYPE 2 NPI	National provider identifier of the medical group (NPI type 2, 10 digits).
GROUP ID	The identification number assigned by CalOptima Health to be used for existing medical groups for demographic changes and terminations (nine digits).
GROUP TIN	The group federal tax ID of the practitioner. Numbers only — no space and no special characters.
SERVICE LOCATION STREET	USPS CASS-certified delivery address street names and their ranges at the practice location. Must use USPS postal addressing standard (Publication 28). No special characters. No punctuation unless a decimal in number (39.2 RD), fractional addresses (39 1/2 RD) or hyphenated addresses (39-3 RD). A space between secondary designator and range: APT = Apartment; BLDG = Building; FL = Floor; STE = Suite; UNIT = Unit; RM = Room; DEPT = Department.
SERVICE LOCATION CITY	City where the practice location is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).
SERVICE LOCATION COUNTY	County where the practice is located.
SERVICE LOCATION STATE	State where the practice is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication28)
SERVICE LOCATION ZIP	Zip code in which the practice is located (five digits). Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).
SECONDARY SPECIALTY	The secondary specialty for which the practitioner is contracted to provide services at the location. When providers practice at multiple sites, they may have different primary and secondary specialties for each site based on the contract.
REMIT STREET	USPS CASS-certified pay-to address street names, secondary address unit designators and their ranges for this practice location. Must use USPS postal addressing standard (Publication 28). No special characters. No punctuation unless a decimal in number (39.2 RD), fractional addresses (39 1/2 RD) or hyphenated addresses (39-3 RD). A space between secondary designator and range: APT = Apartment; BLDG = Building; FL = Floor; STE = Suite; UNIT = Unit; RM = Room; DEPT = Department.
REMIT CITY	City where the pay-to is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).
REMIT STATE	State where the pay-to is located. Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).
REMIT ZIP	Zip code in which the pay-to is located (five digits). Must be USPS CASS-certified and use USPS postal addressing standard (Publication28).
OFFICE MANAGER	Name of the contact person at the practice location.
PHONE NUMBER	Phone number at practice location. No space or special character and 10-digit number only.
FAX NUMBER	Fax number at practice location. No space or special character and 10-digit number only.
PUBLIC EMAIL	Email address the practitioner would like to be published on the directory for inquiries from CalOptima Health members. Note: It is NOT site contact person's email.
ADMINISTRATION EMAIL ADDRESS	Email address the practitioner uses for business correspondence with CalOptima Health only. Note: It is NOT site contact person's email. It is internal use between CalOptima Health and practitioner only.

WEBSITE URL ADDRESS	The website or other online resource for the practice location. Use complete URL syntax including scheme, 2 slashes, authority part and path, with optional query and fragment.
SPECIAL SERVICES	Check all that apply: CCS, CPSP
HOSPITAL / FACILTIY AFFILIATIONS ADMITTING PRIV	The name of CalOptima Health-contracted hospital where the practitioner him/herself is on staff and/or having admitting privilege. Type of privileges includes: NONE, ACTIVE, ASSOCIATE STAFF, HONORARY, CONSULTANT, COURTESY, LIMITED, PROVISIONAL, SENIOR ATTENDING, SURGICAL, SUSPENDED.
ATTESTATION	Yes = HN has received a provider attestation. No = HN has not received a provider attestation. Note it won't be published in provider directory now, but by providing the public email, the provider acknowledges and agrees that the email is for patient communications, regularly monitored, maintained in manner consistent with state and federal health privacy laws, including Health Insurance Portability and Accountability Act (HIPAA) and Confidentiality of Medical Information Act (CMIA).
ACCEPTING NEW PATIENTS	Accepting new patients; No = Not accepting new patients
ACCEPTING EXISTING PATIENTS	Accepting existing patients; No = Not accepting existing patients
ACCEPTING THROUGH REFERRAL	Accepting through referral; No = Not accepting through referral
ACCEPTING THROUGH HOSPITAL FACILITY	Accepting through hospital facility; No = Not accepting through referral
NOT ACCEPTING NEW PATIENTS	Not accepting new patients
PANEL STATUS	The providers panel status is "Open" or "Closed".
OFFICE HOUR SUNDAY	Office hours of the practice location on Sunday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR MONDAY	Office hours of the practice location on Monday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR TUESDAY	Office hours of the practice location on Tuesday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR WEDNESDAY	Office hours of the practice location on Wednesday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR THURSDAY	Office hours of the practice location on Thursday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR FRIDAY	Office hours of the practice location on Friday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
OFFICE HOUR SATURDAY	Office hours of the practice location on Saturday. "CLOSED" if not open. Format is "HH:MI-HH:MI", 11 digits exact and no space. HH is between 00 and 23. Ignore lunch closure. If it opens 8:30am-12pm and 1pm-5pm, then put "08:30-17:00".
SERVICE LOCATION PHONE AFTER-HOURS	Phone number at practice location after hours in case of emergency or urgency. No space or special character and 10-digit number only.
STAFF LANGUAGE	The language spoken by office staff (not providers) at practice location. Use Language tab.

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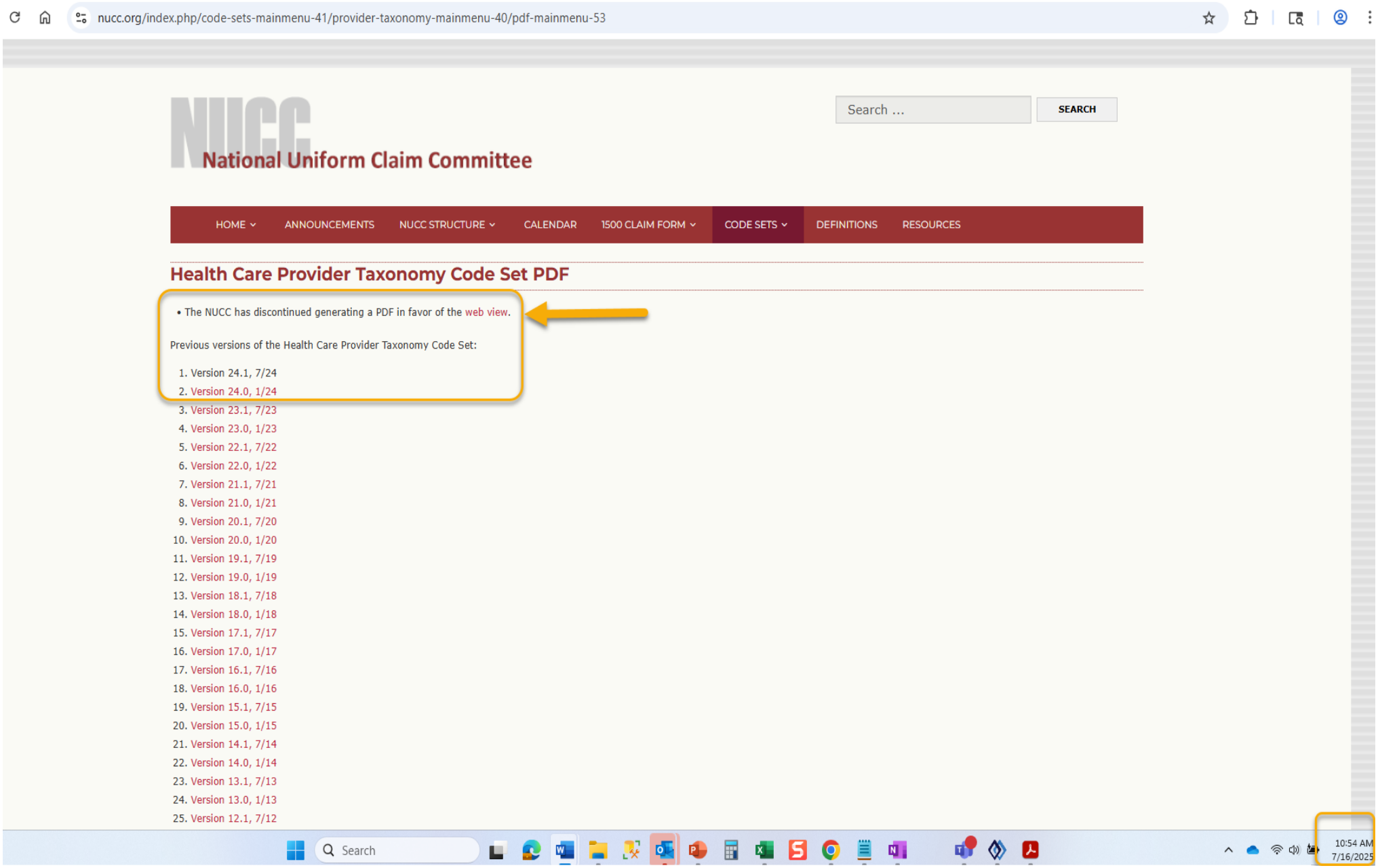
PRACTITIONER LANGUAGE	The language practitioner speaks. Use Language tab.
MEMBER AGE MIN	Use comments section: CalOptima Health member's minimum age that is allowed at the practice location based on provider's contracted specialty. Age is presented in year and no
MEMBER AGE MAX	Use comments section: CalOptima Health member's maximum age that is allowed at the practice location based on provider's contracted specialty. Age is presented in year and no limit = 150.
GENDER RESTRICTION	Use comments section: If the service at the practice location is only accessible to specific gender of CalOptima Health member. F = female member only; M = male member only; NR = no restriction.
TELEHEALTH SITE INDICATORS	Site indicator: Telehealth Only, No Telehealth, or Both Telehealth and In-Person. Use Telehealth Tab.
RACE/ETHNICITY	The Race/Ethnicity of the Provider



The most current Taxonomy Code Set is no longer provided in PDF format.

https://nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40/pdf-mainmenu-53

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CalOptima Health Board Action Agenda Referral

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

Consent Calendar

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

Contacts

John Tanner, Chief Compliance Officer, (657) 235-6997
Kevin Larson, Director, Internal Audit, (714) 246-8745

Recommended Action

Authorize the Chief Executive Officer or designee to execute a contract amendment with Ankura Consulting Group, LLC to extend the contract terms through July 31, 2026, to complete the work of grants close-out review process.

Background and Discussion

At its October 2023 meeting, the CalOptima Health Board of Directors approved an amendment to the contract with Ankura Consulting Group, LLC (Ankura Consulting) to conduct a review of grant funds for compliance and audit readiness.

Subsequently, at its September 2024 meeting, the Board approved a second amendment to include grant close-out review under the existing Ankura contract. This amendment was intended to support CalOptima Health in building out its grant management capabilities and in designing and implementing an improved grant close-out review process.

The amendment specified an expiration date for the additional work of July 31, 2025. As of July 31, 2025, the work has not been fully completed. Staff is requesting a 12-month extension to the current Ankura grant close-out amendment to allow sufficient time to complete the review.

Ankura Consulting is best suited to support CalOptima Health in continuing to implement the grant close-out review. Engaging a different consultant at this stage would require significant time for onboarding and knowledge transfer, which would likely delay the implementation of key recommendations and increase overall project costs.

Fiscal Impact

The estimated annual fiscal impact is $150,000. Funding for the recommended action is a budgeted item under the CalOptima Health Fiscal Year 2025-26 Operating Budget approved by the Board on June 5, 2025.

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Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to protecting financial interests in awarding Board-approved grants and validating that funds are appropriated and used for their intended purpose, CalOptima Health staff recommends that the Board approve and adopt the proposed Scope of Work.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. SOW Grants Management Review 25.08.20 FINAL.pdf
2. Entities Covered by this Recommended Action

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
September 5, 2024	Board approved Report Item #7	Through 7/31/2025	$150,000
October 5, 2023	Board approved Report Item #12	Through 6/30/2024	$200,000
April 6, 2023	Board approved Report Item #16	Through 6/30/2023	$200,000

/s/ Michael Hunn *08/28/2025*

Authorized Signature **Date**

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REQUEST FOR PROPOSAL

I. Objective for Grants Management Administration and Close-Out Reviews

The objective of this engagement is to:

- Assist CalOptima Health with the buildout and implementation of recommendations developed by Ankura Consulting for improving the effective administration and oversight of Board-approved grants and internal initiatives funded through surplus operating reserves.
- Assist CalOptima Health with the development and implementation of an improved monitoring and close-out review process to provide oversight for the effective and appropriate use of funds.
- Assist CalOptima Health by conducting close-out reviews of Board-approved grants and initiatives upon completion to assess compliance with grant/program/project requirements, achievement of objectives, and appropriate use of disbursed funds.

CONSULTANT shall support CalOptima Health's Board-approved grants and initiatives process through the following efforts:

- CONSULTANT shall advise concerning implementation of the opportunities for improvement ("recommendations") outlined in the Ankura Consulting Final Report dated March 15, 2024.
- CONSULTANT shall advance grants management, reporting, policy and playbook concepts that are based on industry standards and commonly accepted best practices.
- CONSULTANT shall provide guidance on the appropriate level of staffing and separation of duties to ensure adequate resources exist to avoid conflicts of interest.
- CONSULTANT shall help design and implement internal controls into the grants management process to prevent other potential risks and deficiencies.
- CONSULTANT shall help design and conduct an improved close-out review process as grants, programs or projects are completed. The close-out review process shall assess the achievement of stated objectives, use of funds, budget control, adherence to grant agreement, adequacy of reporting, and proper exercise of management reviews and approvals throughout the grant lifecycle.
- CONSULTANT shall provide co-sourcing support to aide CalOptima Health's staff with interim and close-out reviews of grants and other internal initiatives through June 30, 2026.

II. Consultant Eligibility Requirements

CONSULTANT shall have a minimum of five years of subject matter expertise in the following areas:

- Familiarity will all stages of the grant lifecycle, including but not limited to: pre-award, award and post-award phases.
- Experience with project and program management, including operating and capital budgets.
- Generally Accepted Accounting Principles (GAAP).
- Public entities and related governance and operating procedures.

III. Consultant's Responsibilities

CONSULTANT shall:

- Perform full Scope of Work according to industry and professional standards and in a manner satisfactory to CalOptima Health by the engagement end date.
- Assign sufficient resources and personnel with requisite subject matter expertise and experience to satisfy the requirements outlined in Scope of Work.
- Provide development tools, outlines, templates, guidelines, or create new resources as needed.
- Under the direction of appointed CalOptima Health staff, schedule and conduct all necessary discovery interviews, collect and review relevant documents and information, compile work product and analysis consistent with Scope of Work, and present relevant findings and recommendations to CalOptima Health leadership.
- Work with CalOptima Health staff to schedule and facilitate discovery meetings/interviews with specified department leaders and provide agendas and other preparatory materials as needed.
- Be available for routine conference calls and meetings with CalOptima Health leadership and staff, including after-hours daily debriefs, to report on the status of work performed, including any hinderances to achieving Scope of Work, for the duration of the project.
- Provide an agreed-upon frequency of written and verbal updates on status of work performed, potential findings, and risks with mitigation to CalOptima Health leadership.
- Prepare and present written reports, in an agreed upon format, of design considerations, findings, deficiencies, discovery of best practices, and opportunities for improvement to CalOptima Health leadership throughout and upon completion of the engagement.

IV. CalOptima Health's Responsibilities

CalOptima Health shall:

- Identify and assign individuals from CalOptima Health to provide direction, approval(s), assistance with discovery and information gathering, and coordination of meetings.
- Provide timely access to requested data, documents, files, policies and procedures, and other information necessary to accomplish Scope of Work.
- Provide facilities and other resources for meetings, interviews, reviews and presentations.
- Act in good faith to complete the project in a timely and cost-effective manner and ensure all deadlines are met.
- Assist CONSULTANT, as requested, on any preparedness efforts related to Scope of Work.

IV. Engagement Timeline

- CalOptima Health shall enter into a contract, or contract extension, with CONSULTANT to last through July 31, 2026.
- CalOptima Health shall utilize CONSULTANT's services to complete the Scope of Work on an as-needed basis throughout the term of the contract.
- CalOptima Health shall provide CONSULTANT with a minimum of three (3) days prior notice before scheduling any meeting of three or more people expected to last 30 minutes or longer. CONSULTANT may accept meetings with shorter notice at CONSULTANT's discretion.

V. Deliverables

CONSULTANT shall:

- Prepare grant management, oversight, pre-award, award and post-award deliverables in an agreed-upon format.
- Upon completion of Close-out Review Reports, CONSULTANT shall prepare an Executive Summary suitable for live presentation to CalOptima Health leadership, in an agreed-upon format. CONSULTANT shall also be available to present the report to CalOptima Health leadership and address any questions.

Attachment to the September 4, 2025 Board of Directors Meeting – Agenda Item 11

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip
Ankura Consulting Group, LLC	485 Lexington Ave., 10th Floor	New York	NY	10017

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CalOptima Health Board Action Agenda Referral

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

Consent Calendar

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

Contacts

Michael Hunn, Chief Executive Officer, (714) 246-8570
Steve Eckberg, Chief Human Resources Officer, (657) 328-9053

Recommended Actions

Adopt Resolution No. 25-0904-01 approving updated CalOptima Health policies:

1. GA.8046: Relocation;
2. GA.8055: Retiree Health Benefit; and
3. GA.8056: Paid Holidays.

Background

Near CalOptima Health's inception, the Board of Directors (Board) delegated authority to the Chief Executive Officer to develop and implement employee policies and procedures and to amend them as appropriate from time to time, subject to bi-annual updates to the Board. CalOptima Health's Bylaws require that the Board adopt by resolution, and from time to time amend, procedures, practices, and policies for, among other things, hiring employees and managing personnel.

Discussion

Staff has included the list of revised policies for Board approval and a summary of changes for the updated policies below.

GA8046 Relocation: This policy sets forth CalOptima Health's guidelines for reimbursing defined expenses incurred for relocation or payment to CalOptima Health's relocation services vendor as a negotiating tool to recruit the most qualified candidates.

Policy Section	Proposed Change	Rationale	Impact
I. Purpose	Add "or payment to our relocation services vendor" to the purpose statement.	Adds option for HR to bring in an external vendor for direct bill for relocation services.	Provides support and functionality to the relocation program.
II. Policy D.	Add Section D "CalOptima Health may provide the candidate or new employee with the opportunity to have a pre-relocation visit to the Central Work Site area for a period of no more than five (5) calendar days after the job offer has been accepted. CalOptima Health will	Adds a provision to allow the incumbent and spouse to visit the worksite after the job offer is accepted but before committing to relocation.	Provides clarity and consistency on pre-relocation travel practices.

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	reimburse for the reasonable costs of travel for the new employee and their spouse/domestic partner."		
III. Procedure A.1.Eligibility	Remove "based on guidelines managed by the Human Resources Department."	Clarifies that the relocation procedure is within the policy, and not in external guidelines.	Provides clarity and consistency on relocation procedure.
III. Procedure A.1.Eligibility	Add "The new employee must relocate their primary residence a minimum of one hundred (100) miles, and the new primary residence must be within fifty (50) miles of the Central Work Site to be eligible for reimbursement."	Adds relocation distance criteria for reimbursement eligibility.	Provides clarity and transparency on qualifying relocation distances.
III. Procedure A.2.Amounts and Package	Remove "and consistent with the guidelines managed by the Human Resources Department."	Clarifies that the relocation procedure is within the policy, and not in external guidelines.	Provides clarity and consistency on relocation procedure.
III. Procedure C.1. Relocation Tax Implications	Add "described in the new hire offer letter" and "Reimbursements will be 'grossed up' to minimize the tax burden associated with relocation expenses."	Adds clarity that the approved relocation reimbursement is in the incumbent's employment offer letter. Adds clarity on how the relocation reimbursement will be calculated for tax purposes.	Provides clarity and consistency in the communication and calculation of relocation reimbursement.
III. Procedure D.1. Common Relocation Expense. b.	Add consecutive "calendar" days.	Adds that the period for storing personal goods is based on calendar days and not business days.	Provides clarity and transparency for eligible expenses.
III. Procedure D.1. Common Relocation Expense. f.	Add "for a period of no more than seven (7) calendar days."	Adds a maximum stay duration for reimbursement for local lodging.	Provides clarity and transparency for eligible expenses.
III. Procedure D.1. Common Relocation Expense. h.	Replace "Using" with "Use or transport of," and replace "vehicle" with "vehicles registered to the new employee."	Adds requirement that vehicle be registered to the incumbent to be eligible for use or transport expense reimbursement.	Provides clarity and transparency for eligible expenses.
III. Procedure D.4	Add "Where a relocation services vendor is not used, the new employee is responsible for obtaining three (3) relocation	Adds requirement and methodology for the incumbent to obtain competitive quotes for	Provides clarity and consistency on pricing services and

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	estimates from different moving companies and submitting them to Human Resources prior to accepting a moving proposal. CalOptima Health will select and authorize the service. CalOptima Health may require additional estimates to be obtained prior to authorization. Maximum total relocation reimbursement is $15,000.00 including gross up. The CEO may grant exceptions to this maximum limit."	relocation services and establishes the maximum reimbursement level that can be approved by Human Resources without CEO approval.	reimbursement limits.

GA:8055 Retiree Health Benefit: This policy provides detailed guidelines on how to administer retiree health benefits for those who qualify for retiree health benefits under this policy.

Policy Section	Proposed Change	Rationale	Impact
Throughout	The policy and procedure has been rewritten and/or reorganized.	Aligns policy to practice on the administration of retiree health benefits.	Provides clarity and conciseness.
II.Policy A.	Add section on "Eligibility criteria" that incorporates criteria that had previously been part of the glossary.	Organizes retiree health benefit eligibility criteria into one policy section.	Provides clarity and conciseness.
II.Policy B.	Revise section on Eligible Participant eligibility to enroll in retiree health benefits into subsections for "Not Medicare Eligible" and "Medicare Eligible".	Provides clarity and simplified language for ease of understanding.	Provides clarity and conciseness.
II.Policy C	Add section "Cost of Coverage" and subsections "Retiree Medical Premium Contributions" and "Stipend for Coverage".	Reorganizes section that determines employer contributions toward retiree medical premiums separately from the employee cost if desired.	Provides clarity and conciseness.
II.Policy E and E.a	Revise section and add subsection that the CEO or designee has discretion to reinstate retiree health benefits when a previously eligible employee separated due to catastrophic leave and is rehired.	Provides clarity and guidance on the reinstatement of benefits to rehired retirees.	Provides clarity and transparency on the reinstatement eligibility of retiree health benefits.
III. Procedure A-B.	Revise the Procedure section to focus on two areas: (1) Section A describes benefit enrollment	Revises and adds language to (i) align with current practice, (ii)	Provides clarity and transparency on the enrollment

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	requirements, and (2) Section B describes termination of benefits. Language updates align with current processes, allow for instances when a retiring employee has not yet retired from CalPERS, when retirees receive health benefits from another employer, allow for flexibility when plan documents change, allow for Qualifying Life events, and align with changes to Glossary terms.	allow for instances when a retiring employee has not yet retired from CalPERS and when retirees receive health benefits from another employer, (iii) allow for flexibility when plan documents change, (iv) allow for Qualifying Life events, and (v) align with changes to glossary terms.	and disenrollment of retiree health benefits.
IX.Glossary	Remove terms Current Retiree, Eligible Retiree, Reinstated Eligible Retiree, Retired Eligible Employee, Retirement Date, Subsequent Retirement Date, and Survivor Dependent from the Glossary.	Removes definitions for terms that are defined within the policy and no longer requires a separate Glossary defined term, and removes terms no longer used in the revised policy and for retiree benefits as administered.	Provides clarity and accuracy of Glossary terms.
IX.Glossary	Revise definition of Eligible Dependent in the Glossary.	Clarifies the use of the term in policy.	Provides clarity and accuracy of Glossary term.
IX.Glossary	Revise the terms and definitions of Eligible Participant (was Eligible Retiree) and Survivor Dependent (was Eligible Survivor Dependent) in the Glossary.	Clarifies the use of the terms in policy.	Provides clarity and accuracy of Glossary terms.

GA.8056: Paid Holidays: This policy establishes the paid holiday schedule for CalOptima Health employees.

Policy Section	Proposed Change	Rationale	Impact
II.Policy A.13	Revise “One Flex Holiday (credited on January 1)” to “One Flex Holiday (credited on January 1 of each calendar year)”.	Provides clarity that the flex holiday is credited based on the calendar year as opposed to fiscal year.	Provides clarity and transparency on Flex Holiday time.
II.Policy D	Add section headings “D. Flex Holiday, 1. Eligibility”, adds “for part-time employees” based on “approved schedule” and renumbers the subsections.	Clarifies the proration of Flex Holiday time for part-time employees and which subsections fall	Provides clarity and transparency on Flex Holiday time.

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		under the Flex Holiday Section heading.	
II.Policy G.	Add "Holiday Early Out" heading and revises section to include "early release" day, "taking their Flex Holiday or other reasons", and "the early release pay".	Clarifies the section topic as Holiday Early Out and adds examples on how to apply Holiday Early Out.	Provides clarity and guidance on the use of Holiday Early Out.
III. Procedure C.	Replace "budgeted" with "assigned" full time equivalency.	Aligns policy to practice in method of prorating paid holiday hours for part time employees.	Provides clarity and transparency.
III. Procedure D.	Remove "full time" and "If a regular, non-exempt part time Employee is required to work a scheduled holiday, they will receive their regular base rate of pay for the holiday, in addition to their regular compensation for the hours of actual work performed".	Clarifies that neither full nor part time status affect eligibility for Holiday Premium Pay in policy GA.8042.	Provides clarity and transparency.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2025-26 Operating Budget.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Adopt Resolution No. 25-0904-01 Approving Updated CalOptima Health Human Resources Policies
2. Updated CalOptima Health policies:
    a. GA.8046: Relocation;
    b. GA.8055; Retiree Health Benefit; and
    c. GA.8056: Paid Holidays.

/s/ Michael Hunn *08/28/2025*
Authorized Signature **Date**

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RESOLUTION NO. 25-0904-01

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

APPROVE UPDATED CALOPTIMA HEALTH HUMAN RESOURCES POLICIES

WHEREAS, Section 13.1 of the CalOptima Health Bylaws provides that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices, and policies for, inter alia, hiring employees, and managing personnel;

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima Health employees at will, to set compensation within the boundaries of the budget limits set by the Board of Directors, to promulgate employee policies and procedures, and to amend said policies and procedures from time to time, subject to annual review by the Board of Directors, or a committee appointed by the Board of Directors for that purpose; and

WHEREAS, staff has revised certain policies and now presents those revised policies to the Board of Directors for approval.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the following updated CalOptima Health Human Resources policies:

1. GA.8046: Relocation
2. GA.8055: Retiree Health Benefit; and
3. GA.8056: Paid Holidays.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 4th day of September 2025.

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AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Isabel Becerra, Chair, CalOptima Health Board of Directors

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

Policy:	GA.8046
Title:	**Relocation**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	02/01/2014
Revised Date:	08/01/2025
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250904 BOD Review Only

I. PURPOSE

This policy sets forth CalOptima Health's guidelines for the reimbursement of defined expenses incurred for relocation or payment to our relocation services vendor as a negotiating tool to recruit the most qualified candidates.

II. POLICY

A. CalOptima Health may provide relocation expenses for new employees if funds are available in the hiring department's budget on a case-by-case basis and in full compliance with Federal Internal Revenue Service (IRS) regulations.

B. CalOptima Health shall comply with all applicable laws and regulations in administering relocation expenses.

C. Reimbursement for relocation expenses should be consistent with CalOptima Health Policy GA.5004: Travel Policy.

D. CalOptima Health may provide the candidate or new employee with the opportunity to have a pre-relocation visit to the Central Worksite area for a period of no more than five (5) calendar days after the job offer has been accepted. CalOptima Health will reimburse for the reasonable costs of travel for the new employee and their spouse/domestic partner.

III. PROCEDURE

A. All or part of a new employee's relocation expenses may be paid for or reimbursed by CalOptima Health when such an incentive assists the organization in the attraction and retention of qualified new hires.

1. ELIGIBILITY – Eligibility for payment of relocation expenses is determined and approved by the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and Chief Human Resources Officer (CHRO~~) based on guidelines managed by the Human Resources Department.~~).. CalOptima Health does not base eligibility on position or title, but on the department's need to use relocation as a recruiting tool. A candidate that is offered relocation

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benefits shall not be eligible to receive payment of relocation expenses until after the candidate has accepted a position, which is defined herein as the point when (i) the candidate has ~~-~~signed and returned ~~to CalOptima Health the countersigned~~their employment offer letter and all other required employment documents and (ii) the candidate has successfully completed the pre-employment screening and background check, and the candidate has commenced work with CalOptima Health. The new employee must relocate their primary residence a minimum of one hundred (100) miles, and the new primary residence must be within fifty (50) miles of the Central Work Site to be eligible for reimbursement.

2. AMOUNTS AND PACKAGE – Individual departments may provide relocation expenses to new employees based on the amount of funds available in the department's budget ~~and consistent with the guidelines managed by the Human Resources Department.~~. The offer letter of employment should specify the approved relocation expenses and define the maximum amount allowable. Relocation expenses are limited to actual and necessary approved relocation expenses, and CalOptima Health shall not pay for any amounts in excess of the actual and necessary approved relocation expenses, even if the new employee's relocation expenses are below the maximum amount allowable. A request for reimbursement of relocation expense must be submitted within a reasonable period of time to the Accounting Department and must be supported by original receipts or equivalent electronic receipts that contain the same level of detail as an acceptable paper receipt or invoice and evidence the purchase of qualifying expenditures.

3. APPROVALS – CalOptima Health's CEO, CFO, and CHRO must approve relocation eligibility, amounts, and package.

B. A department offering payment of relocation expenses to a new employee should use the expense form maintained by the Accounting Department Accounts Payable. Levels of approval must be completed prior to payment. The form must:

1. Identify which relocation expenses will be covered by the hiring department; and

2. Explain how to process payment for relocation expenses.

C. Relocation Tax Implications

1. Under the Tax Cuts and Jobs Act, all employer-paid relocation expenses must be reported as taxable income. Relocation expenses may be covered through a lump sum payment or through reimbursement up to a specific dollar amount~~-~~ described in the new hire offer letter. Both allowances are taxable and will be issued through Payroll. ~~-~~Reimbursements will be "grossed up" to minimize the tax burden associated with relocation expenses. CalOptima Health should advise new employees eligible for relocation to consult their own tax consultants regarding relocation tax implications.

D. Common Relocation Expense

1. Below are common relocation expenses which may be offered to new employees. Expenses are outlined in guidelines provided by the IRS, as may be amended from time to time.

a. Packing, crating, and transporting household goods and personal effects and those of the members of the new employee's household from the new employee's former home to the new home;

For 20250904 BOD Review Only

b. Storing household goods or personal affects en route within any period of thirty (30) consecutive calendar days;

c. Storing household goods or personal effects once at CalOptima Health;

d. Searching for housing or consulting about relocation;

e. Lodging en route for new employee and members of new employee's household;

f. Lodging once in Orange County for a period of no more than seven (7) calendar days (other than first day of arrival);

g. Dining en route and dining once in Orange County;

h. ~~Using~~Use or transport of personal ~~vehicle~~vehicles registered to the new employee; and/or

i. Using commercial transportation.

2. Use of Personal Vehicles: Post-acceptance expenses for use of personal vehicles, such as travel expenses (one (1) trip) to find a new home or moving expenses to transfer to the new location, are considered relocation expenses and shall be reimbursed consistent with CalOptima Health Policy GA.5004: Travel Policy.

3. Use of Commercial Transportation: Use of commercial transportation (i.e., airlines, trains, etc.) when relocating may be reimbursed by CalOptima Health, including transportation for family members. However, only one-way trips, without side excursions, are reimbursable by CalOptima Health.

4. Where a relocation services vendor is not used, the new employee is responsible for obtaining three (3) relocation estimates from different moving companies and submitting them to the Human Resources Department prior to accepting a moving proposal. CalOptima Health will select and authorize the service. CalOptima Health may require additional estimates to be obtained prior to authorization. Maximum total relocation reimbursement is $15,000.00 including gross up. The CEO may grant exceptions to this maximum limit.

IV. ATTACHMENTS

Not Applicable

V. REFERENCE(S)

A. 26 U.S.C. §132(g)
B. CalOptima Health Expense Reporting Reference Guide
C. CalOptima Health Policy GA.5004: Travel Policy

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors

For 2025004 BOD Review Only

04/06/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program (s)
Effective	02/01/2014	GA.8046	Relocation	Administrative
Revised	04/06/2017	GA.8046	Relocation	Administrative
Revised	12/01/2022	GA.8046	Relocation	Administrative
Revised	08/01/2025	GA.8046	Relocation	Administrative

For 20250904 BOD Review C

IX. GLOSSARY

~~Not Applicable~~

Term	Definition
Central Worksite	CalOptima Health's primary physical location of business applicable to the employee, which is either CalOptima Health's administration building at 505 City Parkway West, the PACE building or other CalOptima Health operated location.

For 20250904 BOD Review Only

Policy:	GA.8046
Title:	**Relocation**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	02/01/2014
Revised Date:	08/01/2025
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250904 BOD Review Only

I. PURPOSE

This policy sets forth CalOptima Health's guidelines for the reimbursement of defined expenses incurred for relocation or payment to our relocation services vendor as a negotiating tool to recruit the most qualified candidates.

II. POLICY

A. CalOptima Health may provide relocation expenses for new employees if funds are available in the hiring department's budget on a case-by-case basis and in full compliance with Federal Internal Revenue Service (IRS) regulations.

B. CalOptima Health shall comply with all applicable laws and regulations in administering relocation expenses.

C. Reimbursement for relocation expenses should be consistent with CalOptima Health Policy GA.5004: Travel Policy.

D. CalOptima Health may provide the candidate or new employee with the opportunity to have a pre-relocation visit to the Central Worksite area for a period of no more than five (5) calendar days after the job offer has been accepted. CalOptima Health will reimburse for the reasonable costs of travel for the new employee and their spouse/domestic partner.

III. PROCEDURE

A. All or part of a new employee's relocation expenses may be paid for or reimbursed by CalOptima Health when such an incentive assists the organization in the attraction and retention of qualified new hires.

1. ELIGIBILITY – Eligibility for payment of relocation expenses is determined and approved by the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and Chief Human Resources Officer (CHRO).. CalOptima Health does not base eligibility on position or title, but on the department's need to use relocation as a recruiting tool. A candidate that is offered relocation benefits shall not be eligible to receive payment of relocation expenses until after the

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candidate has accepted a position, which is defined herein as the point when (i) the candidate has signed and returned their employment offer letter and all other required employment documents and (ii) the candidate has successfully completed the pre-employment screening and background check, and the candidate has commenced work with CalOptima Health. The new employee must relocate their primary residence a minimum of one hundred (100) miles, and the new primary residence must be within fifty (50) miles of the Central Work Site to be eligible for reimbursement.

2. AMOUNTS AND PACKAGE – Individual departments may provide relocation expenses to new employees based on the amount of funds available in the department's budget. The offer letter of employment should specify the approved relocation expenses and define the maximum amount allowable. Relocation expenses are limited to actual and necessary approved relocation expenses, and CalOptima Health shall not pay for any amounts in excess of the actual and necessary approved relocation expenses, even if the new employee's relocation expenses are below the maximum amount allowable. A request for reimbursement of relocation expense must be submitted within a reasonable period of time to the Accounting Department and must be supported by original receipts or equivalent electronic receipts that contain the same level of detail as an acceptable paper receipt or invoice and evidence the purchase of qualifying expenditures.

3. APPROVALS – CalOptima Health's CEO, CFO, and CHRO must approve relocation eligibility, amounts, and package.

B. A department offering payment of relocation expenses to a new employee should use the expense form maintained by the Accounting Department Accounts Payable. Levels of approval must be completed prior to payment. The form must:

1. Identify which relocation expenses will be covered by the hiring department; and

2. Explain how to process payment for relocation expenses.

C. Relocation Tax Implications

1. Under the Tax Cuts and Jobs Act, all employer-paid relocation expenses must be reported as taxable income. Relocation expenses may be covered through a lump sum payment or through reimbursement up to a specific dollar amount described in the new hire offer letter. Both allowances are taxable and will be issued through Payroll. Reimbursements will be "grossed up" to minimize the tax burden associated with relocation expenses. CalOptima Health should advise new employees eligible for relocation to consult their own tax consultants regarding relocation tax implications.

D. Common Relocation Expense

1. Below are common relocation expenses which may be offered to new employees. Expenses are outlined in guidelines provided by the IRS, as may be amended from time to time.

a. Packing, crating, and transporting household goods and personal effects and those of the members of the new employee's household from the new employee's former home to the new home;

b. Storing household goods or personal affects en route within any period of thirty (30) consecutive calendar days;

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c. Storing household goods or personal effects once at CalOptima Health;

d. Searching for housing or consulting about relocation;

e. Lodging en route for new employee and members of new employee's household;

f. Lodging once in Orange County for a period of no more than seven (7) calendar days (other than first day of arrival);

g. Dining en route and dining once in Orange County;

h. Use or transport of personal vehicles registered to the new employee; and/or

i. Using commercial transportation.

2. Use of Personal Vehicles: Post-acceptance expenses for use of personal vehicles, such as travel expenses (one (1) trip) to find a new home or moving expenses to transfer to the new location, are considered relocation expenses and shall be reimbursed consistent with CalOptima Health Policy GA.5004: Travel Policy.

3. Use of Commercial Transportation: Use of commercial transportation (i.e., airlines, trains, etc.) when relocating may be reimbursed by CalOptima Health, including transportation for family members. However, only one-way trips, without side excursions, are reimbursable by CalOptima Health.

4. Where a relocation services vendor is not used, the new employee is responsible for obtaining three (3) relocation estimates from different moving companies and submitting them to the Human Resources Department prior to accepting a moving proposal. CalOptima Health will select and authorize the service. CalOptima Health may require additional estimates to be obtained prior to authorization. Maximum total relocation reimbursement is $15,000.00 including gross up. The CEO may grant exceptions to this maximum limit.

IV. ATTACHMENTS

Not Applicable

V. REFERENCE(S)

A. 26 U.S.C. §132(g)
B. CalOptima Health Expense Reporting Reference Guide
C. CalOptima Health Policy GA.5004: Travel Policy

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
04/06/2017	Regular Meeting of the CalOptima Board of Directors
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For 20250904 BOD Review Only

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program (s)
Effective	02/01/2014	GA.8046	Relocation	Administrative
Revised	04/06/2017	GA.8046	Relocation	Administrative
Revised	12/01/2022	GA.8046	Relocation	Administrative
Revised	08/01/2025	GA.8046	Relocation	Administrative

For 20250904 BOD Review Only

IX. GLOSSARY

Term	Definition
Central Worksite	CalOptima Health's primary physical location of business applicable to the employee, which is either CalOptima Health's administration building at 505 City Parkway West, the PACE building or other CalOptima Health operated location.

For 20250904 BOD Review Only

Policy:	GA.8055
Title:	**Retiree Health Benefit**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	08/01/2025
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250904 BOD Review Only

I. PURPOSE

This policy provides detailed guidelines on how to administer retiree health benefits for those who qualify for retiree health benefits under this policy.

II. POLICY

A. ~~Retiree health benefits are available to Current Retirees, Eligible~~ Eligibility criteria:

1. Employees~~, and Eligible Retirees. Retiree~~ are eligible for retiree health benefits ~~are not available to employees who: (1)~~if:

a. They were initially hired on or ~~after January 1, 2004, or (2) employees who were hired or rehired on or after~~before December ~~1~~31, 2003, and

b. They have no break in service with CalOptima Health, or their most recent rehire date was before December 31, 2013, and

~~A.~~ They complete at least five (5) years of pensionable service (with the ~~exception of Reinstated Eligible Retirees).~~

c. ~~Eligible Retirees and, if elected~~California Public Employees' Retirement System (CalPERS) and ~~paid for by the Eligible Retirees, the Eligible Dependents~~/or reciprocal service with another California public agency), and

d. They retire with CalPERS within sixty (60) calendar days of ~~Current Retirees, Retired Eligible Employees, or Reinstated Eligible Retirees, will, until the CalOptima Health Board of Directors ("Board") decides that~~separation from CalOptima Health ~~will no longer continue the program or otherwise modifies it,~~.

B. Eligible Participants will be ~~eligible~~able to ~~receive~~enroll in retiree health benefits as follows:

~~1. *Not Medicare Eligible*: If the Eligible Retiree and/or the Eligible Dependent(s) is/are not yet eligible for Medicare, then the Eligible Retiree and/or the Eligible Dependent(s) will receive the same health insurance coverage as active employees and their dependents subject to the~~

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~~limitations below. The Eligible Retiree's share of premiums for the Eligible Retiree's health insurance coverage will be the same as those paid by active employees for similar coverage. In the event CalOptima Health is unable to reasonably obtain health insurance coverage for the Eligible Dependent(s) who are not Medicare eligible, CalOptima Health may provide a stipend to the Eligible Dependent(s) in lieu of health insurance coverage in an amount calculated based on the proportional amount CalOptima Health pays for the most closely analogous active employee health insurance coverage for active employees and their dependent(s), but in no event shall the total dollar amount for the stipend be more than the amount CalOptima Health would have paid for the most closely analogous health insurance coverage for the Eligible Dependent(s). Proof of coverage, along with evidence of payments for health care coverage, must be submitted to CalOptima Health in order for the stipend to be paid.~~

1. *Not Medicare Eligible:* If the Eligible Participant or their Eligible Dependent(s) is not yet eligible for Medicare, they will receive the same health insurance coverage as active employees.

2. *Medicare Eligible:* If the Eligible ~~Retiree and/~~Participant or ~~the~~their Eligible Dependent(s) is~~/are~~ eligible for Medicare ~~eligible, then the Eligible Retiree and/or the Eligible Dependent(s) will be required to~~, they must enroll~~, at the Eligible Retiree's expense,~~ in Medicare Part A and~~/or~~ Part B~~, as a condition of receiving~~ at their own cost in order to receive retiree health benefits ~~under this policy.~~.

   a. Proof of Medicare coverage must be submitted to Human Resources~~.~~ upon initial enrollment.

   b. The Eligible ~~Retiree~~Participant may select one (1) of the Medicare supplemental coverage options offered by CalOptima Health ~~for the Medicare Eligible Retiree and/or the Eligible Dependent(s). The Eligible Retiree's share of the~~.

C. Cost of Coverage:

1. *Retiree Medical Premium Contributions:* CalOptima Health's retiree medical premium contributions are determined annually (such as a fixed percentage of the total premium or a flat dollar amount), as determined during the renewal process for the specified plan year. CalOptima Health reserves the right to adjust the retiree contribution amount each year as part of the annual renewal process. Any changes to the retiree contribution structure will be communicated to retirees during the open enrollment period.

2. *Stipend for Coverage:* If CalOptima Health is unable to provide coverage for an Eligible Dependent or Eligible Participant, a stipend may be offered in lieu of coverage. The stipend amount will not exceed the cost of similar coverage provided to active employees or, for Medicare-eligible individuals, the cost of similar Medicare supplemental coverage ~~premium will be calculated based on the same proportional amount active employees pay for the most closely analogous active employee health insurance coverage for the active employee and their dependents. In the event CalOptima Health is unable to reasonably obtain Medicare Supplemental coverage for the Eligible Dependent(s) who are Medicare eligible, CalOptima Health may provide a stipend to the Eligible Dependent(s) in lieu of Medicare Supplemental coverage in an amount calculated based on the proportional amount CalOptima Health pays for the most closely analogous Medicare supplemental coverage for Eligible Retirees and their dependent(s), but in no event shall the total dollar amount for the stipend be more than the amount CalOptima Health would have paid for the most closely analogous Medicare Supplemental coverage for the Eligible Dependent(s). Proof of coverage, along with evidence of payments for Medicare Supplemental coverage,~~. To receive the stipend, proof of coverage

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and payment must be ~~submitted to CalOptima Health in order for the stipend to be paid~~provided.

~~C.~~D. This retiree health benefit policy is completely voluntary on the part of CalOptima Health and may be amended, or terminated, by the CalOptima Health Board at any time in its sole discretion. This policy shall not create any vested benefits for any person, or categories of persons.

~~D.~~E. The Chief Executive Officer of CalOptima Health is charged with administering and interpreting this policy. ~~When addressing any issue that is not dealt with in the Policy, the Chief Executive Officer shall consider and give weight to what the result would have been if CalOptima Health were still providing its employee health insurance through CalPERS.~~

a. At the discretion of the Chief Executive Officer or their designee, employees who initially met the eligibility criteria, separated due to a catastrophic or unplanned event, and were later rehired, may have their retiree health benefits eligibility reinstated, provided this is expressly granted at the time of rehire.

~~E.~~F. This policy shall supersede any and all prior Board actions or policies concerning retiree health benefits.

III. PROCEDURE

A. The following provisions set forth the enrollment requirements ~~for an Eligible Retiree~~ to receive ~~Retiree Health Benefits~~retiree health benefits:

~~1. A Retired~~An Eligible ~~Employee~~Participant must enroll themself and their Eligible Dependents within sixty (60) calendar days of ~~the Retired Eligible Employee's Retirement Date or must wait to enroll during the annual open enrollment period applicable to active employees.~~

~~2. An Eligible Retiree must elect the Medicare coverage option they want within sixty (60) calendar days of the Eligible Retiree and/or the Eligible Dependent becoming Medicare eligible and provide proof of Medicare coverage to Human Resources.~~

~~3.~~1. ~~A Reinstated Eligible Employee must enroll within sixty (60) calendar days of~~ their ~~Subsequent Retirement Date.~~separation from CalOptima Health and their retirement date with CalPERS. If they do not enroll within this timeframe, they must wait for the next annual open enrollment period unless they experience a qualifying life event as defined by the IRS.

~~4. A Survivor Dependent may continue coverage without interruption or enroll for Survivor Dependent coverage by submitting all necessary documentation within sixty (60) calendar days of the death of the Eligible Retiree.~~

~~5. Health insurance coverage options may be changed by an Eligible Retiree during the annual open enrollment period and for defined qualifying events applicable for active employees who are covered under CalOptima Health's employee health plan.~~

~~B. Retiree health benefits coverage will begin upon one (1) of the following:~~

a. If an Eligible ~~Employee~~Participant enrolls within sixty (60) calendar days of separation from CalOptima Health and their ~~Retirement Date, then the~~CalPERS retirement date, retiree health ~~benefits~~benefit coverage ~~for the Retired Eligible Employee and the Eligible Dependent(s)~~ will begin on the first day of the month following ~~the date~~their CalOptima

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Health ~~timely receives the completed health enrollment forms from the Eligible Employee~~separation date.

b. If the ~~Retired~~ Eligible ~~Employee~~Participant fails to enroll within sixty (60) calendar days ~~of their Retirement Date~~, but ~~subsequently~~later enrolls during any future open enrollment period ~~applicable for active employees,~~ , their retiree health ~~benefits~~benefit coverage will begin on ~~the following~~ January 1 of the following calendar year.

2. ~~Retiree health benefits~~When the Eligible Participant and/or the Eligible Dependent become Medicare eligible, they must elect Medicare supplemental coverage ~~for an Eligible~~ and provide proof of Medicare Part A and Part B coverage to Human Resources within sixty (60) calendar days.

~~1.~~3. A Survivor Dependent ~~will continue uninterrupted upon submission of all~~has sixty (60) calendar days from the date of the retiree's death to make changes or continue existing coverage by providing required documentation ~~or begin on the first day of the month following timely enrollment for coverage as a~~ , including the death certificate, to Human Resources. The deceased must have been enrolled in coverage at the time of death for the Survivor Dependent to be eligible for coverage. If no changes are made, the Survivor Dependent's retiree health benefit coverage will continue without interruption. If changes are made, they will take effect on the first day of the month following the date of death.

~~2. If a Reinstated Eligible Employee timely enrolls within sixty (60) calendar days of their Subsequent Retirement Date, then the retiree health benefits coverage for the Reinstated Eligible Employee and the Eligible Dependent(s) will begin on the first day of the month following the date CalOptima Health timely receives the completed health enrollment forms from the Reinstated Eligible Employee.~~

~~C. If an Eligible Employee separates from CalOptima Health before CalOptima Health receives notice from CalPERS that the Eligible Employee has/will become an annuitant, the Eligible Employee will be offered termination of health coverage information and a COBRA health plan continuation packet. After CalOptima Health receives notice from CALPERS of the Eligible Employee's retirement effective date, CalOptima Health will forward a packet to the Retired Eligible Employee concerning retiree health benefits. The Retired Eligible Employee must enroll themself and their Eligible Dependents within sixty (60) calendar days of the Retired Eligible Employee's Retirement Date or must wait to enroll during the next annual open enrollment period applicable to active employees. (NOTE: If the retirement effective date indicated by CalPERS is postdated to the date of separation or other earlier date, and CalOptima Health does not receive notice from CalPERS until more than sixty (60) calendar days after such date, the Retired Eligible Employee must wait to enroll during the next annual open enrollment period.). If the Retired Eligible Employee needs access to health coverage before the retiree health benefits coverage will begin, the Retired Eligible Employee will need to elect and pay for COBRA health plan continuation or pay for an alternative health plan until then.~~

~~D.~~B. Retiree health benefit coverage will terminate upon the following:

1. For Eligible ~~Retirees~~Participants, upon death of the Eligible ~~Retiree~~Participant.

2. For Eligible Dependents, upon death of the Eligible ~~Retiree~~Participant, unless ~~the Eligible Dependent is an Eligible~~they are an eligible Survivor Dependent.

~~3. For Current Retirees and Retired~~ Eligible ~~Employees who are~~ Participants reinstated from retirement~~:~~

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a. During the period of reinstatement that ends CalPERS retirement annuity payments; and

4.3. During and after the Subsequent Retirement Date if the Current Retiree and/or Retired Eligible Employee subsequently terminates employment from another California public employer who provides are not eligible for retiree health benefits with a retiree share premium that is less than, or equal to, that being charged by CalOptima Health under this policywhile receiving health benefits from another employer. These members must inform CalOptima Health if they are enrolled in health benefits through another employer. They may reenroll in CalOptima Health retiree health benefits if they separate from employment and begin receiving annuity payments from CalPERS, or lose coverage due to a qualifying life event, as defined by the IRS.

5.4. Upon the failure of an Eligible RetireeParticipant or Eligible Survivor Dependent to pay any required premiums within ninety (90) calendar days of payment due date, or as defined in the applicable plan document.

6.5. When the CalOptima Health Board elects to terminate retiree health benefits, in part,either partially or in its entiretyfully.

7. Upon the failureIf the Eligible Participant or Eligible Dependent fails to obtain and certify Medicare coverage within ninety (90) calendar days upon the Eligible Retiree or the Eligible Dependent(s) becoming Medicare eligible.

8.6. Upon the failure of an Eligible Retireeof turning 65, or Eligible Dependentif they fail to maintain the required Medicare coverage.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
08/07/2014	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

F 20250904 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8055	Retiree Health Benefit Policy	Administrative
Revised	08/07/2014	GA.8055	Retiree Health Benefit Policy	Administrative
Revised	06/02/2016	GA.8055	Retiree Health Benefit	Administrative
Revised	11/03/2016	GA.8055	Retiree Health Benefit	Administrative
~~Revised~~	~~11/07/2019~~	~~GA.8055~~	~~Retiree Health Benefit~~	~~Administrative~~
Revised	06/04/2020	GA.8055	Retiree Health Benefit	Administrative
Revised	12/01/2022	GA.8055	Retiree Health Benefit	Administrative
Revised	08/01/2025	GA.8055	Retiree Health Benefit	Administrative

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IX. GLOSSARY

Term	Definition
~~Current Retiree~~	~~Former employee of CalOptima Health who:~~ ~~1. Was hired before January 1, 2004;~~ ~~2. Completed at least five (5) years of pensionable service (with CalOptima Health and/or combined with other service with a public agency that participates in CalPERS); and~~ ~~3. Was already receiving retiree health benefits from CalOptima Health on January 1, 2014.~~
Eligible Dependent	The current spouse, registered domestic partner, dependent child up to age 26, and/or certified disabled dependent child over age 26, of ~~a Current Retiree, Retired~~an Eligible ~~Employee, or Reinstated Eligible Retiree~~Participant, who~~:~~ ~~1. Meets~~ meets the definition of a dependent who is eligible for coverage under the employee health plan then maintained by CalOptima Health for its active employees~~; and~~ ~~Has been timely enrolled for coverage under this retiree health policy by the Eligible Retiree.~~.
Eligible ~~Employee~~Participant	~~A current~~For purposes of this policy, active ~~employee of CalOptima Health meeting~~employees and retirees who meet the ~~following~~eligibility criteria~~:~~ ~~1. The most recent date of hire was before January 1, 2004, or whose initial date of hire was before January 1, 2004, and whose most recent rehire date was before December 1, 2013;~~ ~~Completes at least five (5) years of pensionable service (with CalOptima Health and/or combined with other service with a public agency that participates~~ outlined in ~~CalPERS).~~Section II.A of this policy.
~~Eligible Retiree~~	~~Current Retiree, Retired Eligible Employee, Reinstated Eligible Retiree or Eligible Survivor Dependent.~~
~~Eligible~~ Survivor Dependent	~~A Survivor~~An Eligible Dependent who ~~timely~~meets the qualifications and enrolls ~~for Survivor Dependent~~ in retiree health coverage within ~~sixty (60) calendar days of~~the required timeframe following the death of the Eligible ~~Retiree.~~Participant. The Survivor Dependent must maintain continuous coverage following the death of the Eligible Participant in order to remain eligible for retiree health benefits.

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Term	Definition
~~Reinstated Eligible Retiree~~	~~A Current Retiree or Retired Eligible Employee whose CalPERS retirement annuity and benefits under this Policy ended due to a reinstatement from retirement as defined in Government Code §§22838 and 21190 et.seq., or successor sections, and who (i) subsequently terminates employment from another California public employer who does not provide retiree health benefits with a retiree share premium that is less than or equal to that being charged by CalOptima Health under this Policy; (ii) once again begins collecting retirement annuity payments from CalPERS within one hundred twenty (120) calendar days of such subsequent separation from employment; and (iii) timely enrolls for resumption of coverage under this Policy.~~
~~Retired Eligible Employee~~	~~Eligible Employee who:~~ ~~1. Retires within one hundred twenty (120) calendar days of such Eligible Employee's separation from employment with CalOptima Health and receives a monthly retirement allowance from CalPERS; and~~ ~~2. Timely applies for retiree health benefits in accordance with this policy on and after January 1, 2014.~~
~~Retirement Date~~	~~Date Eligible Employee becomes an annuitant with CalPERS within one hundred twenty (120) calendar days of such Eligible Employee's separation from employment with CalOptima Health.~~
~~Subsequent Retirement Date~~	~~Date Reinstated Eligible Retiree again begins collecting retirement annuity payments from CalPERS within one hundred twenty (120) calendar days of separating from employment with the subsequent state employer described in that definition.~~
~~Survivor Dependent~~	~~Eligible Dependent who:~~ ~~1. Survives an Eligible Retiree; and~~ ~~2. Is collecting monthly survivor benefits from CalPERS that is attributable to a deceased Current Retiree, Retired Eligible Employee, or Reinstated Eligible Employee.~~

For 20250904 BOD Review Only

Policy:	GA.8055
Title:	**Retiree Health Benefit**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	08/01/2025
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250904 BOD Review Only

I. PURPOSE

This policy provides detailed guidelines on how to administer retiree health benefits for those who qualify for retiree health benefits under this policy.

II. POLICY

A. Eligibility criteria:

1. Employees are eligible for retiree health benefits if:

   a. They were initially hired on or before December 31, 2003, and

   b. They have no break in service with CalOptima Health, or their most recent rehire date was before December 31, 2013, and

   c. They complete at least five (5) years of pensionable service (with the California Public Employees' Retirement System (CalPERS) and/or reciprocal service with another California public agency), and

   d. They retire with CalPERS within sixty (60) calendar days of separation from CalOptima Health.

B. Eligible Participants will be able to enroll in retiree health benefits as follows:

1. *Not Medicare Eligible:* If the Eligible Participant or their Eligible Dependent(s) is not yet eligible for Medicare, they will receive the same health insurance coverage as active employees.

2. *Medicare Eligible:* If the Eligible Participant or their Eligible Dependent(s) is eligible for Medicare, they must enroll in Medicare Part A and Part B at their own cost in order to receive retiree health benefits.

   a. Proof of Medicare coverage must be submitted to Human Resources upon initial enrollment.

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b. The Eligible Participant may select one (1) of the Medicare supplemental coverage options offered by CalOptima Health.

C. Cost of Coverage:

1. *Retiree Medical Premium Contributions:* CalOptima Health's retiree medical premium contributions are determined annually (such as a fixed percentage of the total premium or a flat dollar amount), as determined during the renewal process for the specified plan year. CalOptima Health reserves the right to adjust the retiree contribution amount each year as part of the annual renewal process. Any changes to the retiree contribution structure will be communicated to retirees during the open enrollment period.

2. *Stipend for Coverage:* If CalOptima Health is unable to provide coverage for an Eligible Dependent or Eligible Participant, a stipend may be offered in lieu of coverage. The stipend amount will not exceed the cost of similar coverage provided to active employees or, for Medicare-eligible individuals, the cost of similar Medicare supplemental coverage. To receive the stipend, proof of coverage and payment must be provided.

D. This retiree health benefit policy is completely voluntary on the part of CalOptima Health and may be amended, or terminated, by the CalOptima Health Board at any time in its sole discretion. This policy shall not create any vested benefits for any person, or categories of persons.

E. The Chief Executive Officer of CalOptima Health is charged with administering and interpreting this policy.

a. At the discretion of the Chief Executive Officer or their designee, employees who initially met the eligibility criteria, separated due to a catastrophic or unplanned event, and were later rehired, may have their retiree health benefits eligibility reinstated, provided this is expressly granted at the time of rehire.

F. This policy shall supersede any and all prior Board actions or policies concerning retiree health benefits.

III. PROCEDURE

A. The following provisions set forth the enrollment requirements to receive retiree health benefits:

1. An Eligible Participant must enroll themself and their Eligible Dependents within sixty (60) calendar days of their separation from CalOptima Health and their retirement date with CalPERS. If they do not enroll within this timeframe, they must wait for the next annual open enrollment period unless they experience a qualifying life event as defined by the IRS.

a. If an Eligible Participant enrolls within sixty (60) calendar days of separation from CalOptima Health and their CalPERS retirement date, retiree health benefit coverage will begin on the first day of the month following their CalOptima Health separation date.

b. If the Eligible Participant fails to enroll within sixty (60) calendar days, but later enrolls during any future open enrollment period, their retiree health benefit coverage will begin on January 1 of the following calendar year.

2. When the Eligible Participant and/or the Eligible Dependent become Medicare eligible, they must elect Medicare supplemental coverage and provide proof of Medicare Part A and Part B coverage to Human Resources within sixty (60) calendar days.

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3. A Survivor Dependent has sixty (60) calendar days from the date of the retiree's death to make changes or continue existing coverage by providing required documentation, including the death certificate, to Human Resources. The deceased must have been enrolled in coverage at the time of death for the Survivor Dependent to be eligible for coverage. If no changes are made, the Survivor Dependent's retiree health benefit coverage will continue without interruption. If changes are made, they will take effect on the first day of the month following the date of death.

B. Retiree health benefit coverage will terminate upon the following:

1. For Eligible Participants, upon death of the Eligible Participant.

2. For Eligible Dependents, upon death of the Eligible Participant, unless they are an eligible Survivor Dependent.

3. Eligible Participants reinstated from retirement are not eligible for retiree health benefits with CalOptima Health while receiving health benefits from another employer. These members must inform CalOptima Health if they are enrolled in health benefits through another employer. They may reenroll in CalOptima Health retiree health benefits if they separate from employment and begin receiving annuity payments from CalPERS, or lose coverage due to a qualifying life event, as defined by the IRS.

4. Upon the failure of an Eligible Participant or Survivor Dependent to pay any required premiums within ninety (90) calendar days of payment due date, or as defined in the applicable plan document.

5. When the CalOptima Health Board elects to terminate retiree health benefits, either partially or fully.

6. If the Eligible Participant or Eligible Dependent fails to obtain and certify Medicare coverage within ninety (90) calendar days of turning 65, or if they fail to maintain the required Medicare coverage.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
08/07/2014	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

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12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8055	Retiree Health Benefit Policy	Administrative
Revised	08/07/2014	GA.8055	Retiree Health Benefit Policy	Administrative
Revised	06/02/2016	GA.8055	Retiree Health Benefit	Administrative
Revised	11/03/2016	GA.8055	Retiree Health Benefit	Administrative
Revised	06/04/2020	GA.8055	Retiree Health Benefit	Administrative
Revised	12/01/2022	GA.8055	Retiree Health Benefit	Administrative
Revised	08/01/2025	GA.8055	Retiree Health Benefit	Administrative

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IX. GLOSSARY

Term	Definition
Eligible Dependent	The current spouse, registered domestic partner, dependent child up to age 26, and/or certified disabled dependent child over age 26, of an Eligible Participant, who meets the definition of a dependent who is eligible for coverage under the employee health plan then maintained by CalOptima Health for its active employees.
Eligible Participant	For purposes of this policy, active employees and retirees who meet the eligibility criteria outlined in Section II.A of this policy.
Survivor Dependent	An Eligible Dependent who meets the qualifications and enrolls in retiree health coverage within the required timeframe following the death of the Eligible Participant. The Survivor Dependent must maintain continuous coverage following the death of the Eligible Participant in order to remain eligible for retiree health benefits.

For 20250904 BOD Review Only

Policy:	GA.8056
Title:	**Paid Holidays**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	04/01/2014
Revised Date:	08/01/2025
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250904 BOD Review Only

I. PURPOSE

This policy establishes the paid holiday schedule for CalOptima Health Employees.

II. POLICY

A. The following holidays shall be observed by CalOptima Health:

1. New Year's Day
2. Martin Luther King Jr's Birthday
3. Lincoln's Birthday
4. Washington's Birthday
5. Memorial Day
6. Independence Day
7. Labor Day
8. Indigenous Peoples' Day
9. Veterans Day
10. Thanksgiving Day
11. Day after Thanksgiving
12. Christmas Day
13. One Flex Holiday (credited on January 1~~)~~ of each calendar year)

B. To receive holiday pay, Employees must work or be paid for the regularly scheduled workdays preceding and following the CalOptima Health holiday.

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1. If a paid holiday occurs during the period an Employee is on a Leave of Absence (LOA), the Employee may be eligible for the holiday pay if Paid Time Off (PTO) is being used for the LOA the day before and the day after the holiday, and the holiday pay will be prorated based on the Employee's full-time or part-time status as it was in effect prior to the LOA. If a holiday falls on a day in which the Employee would have been regularly scheduled to work, the holiday will count against the Employee's LOA entitlement.

C. A holiday that falls on a Saturday or Sunday can be observed on the preceding Friday or the following Monday. Holiday observances will be noted on the annual payroll schedule. Employees will be provided with notice of any changes to the published schedule.

D. Flex Holiday

1. Eligibility

a. Current Employees in active status on December 31st are eligible to ~~receive~~earn a maximum of one (1) Flex Holiday ~~(~~a maximum of eight (8) hours, (prorated for part-time employees based on ~~scheduled work hours~~approved schedule) each calendar year on January 1st.

2. Limits are imposed on the number of Flex Holiday hours that can be maintained in an Employee's Flex Holiday account. A maximum of twelve (12) hours, prorated based on scheduled work hours, may be maintained in an Employee's Flex Holiday account as of January 1st of each year. In the event that available Flex Holiday hours are not used by the last pay period of the calendar year, Employees may carry unused Flex Holiday hours into subsequent years and may accrue additional hours up to the maximum of eight (8) hours, prorated based on scheduled work hours. If an Employee reached the maximum amount of twelve (12) hours on January 1st, prorated based on scheduled work hours, the Employee will stop accruing Flex Holiday hours.

3. Flex Holiday hours are not eligible for annual cash out applicable to Paid Time Off (PTO) hours.

4. The Chief Executive Officer (CEO) may assign a specific date for the Flex Holiday for business reasons and/or needs. Assignment of the Flex Holiday will be announced in advance. Otherwise, Employees may take the Flex Holiday on any day elected by the Employee, subject to approval by the Employee's manager.

~~1.~~5. If an Employee separates from CalOptima Health and has unused Flex Holiday hours, the unused Flex Holiday hours will be paid out at the same time and in the same manner as unused PTO hours upon termination.

~~2.~~ Employees on an approved leave of absence on December 31st will be eligible to receive a maximum of one (1) Flex Holiday (maximum of eight (8) hours, prorated based on scheduled work hours) upon their return to active status.

~~3.~~6. If the Employee does not return to work after their approved leave of absence, and instead separates from employment with CalOptima Health, the Employee will not be eligible to receive the Flex Holiday.

~~D.~~E. Regular full-time and regular part-time Employees shall be paid their base rate of pay for the holidays specified in this Policy.

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~~E.~~F. CalOptima Health may, in its discretion, amend the list of paid holidays and/or require an Employee to work on one or more of the observed holidays.

~~F.~~G. Holiday Early Out: From time to time, at the discretion of the CEO, the CEO, or their Designee, may authorize managers, at their discretion, to release Employees early, up to a maximum of two (2) hours, with pay, on the workday immediately preceding a holiday, as long as departments ensure critical areas are covered for the entire business day. The release of Employees early as provided herein is intended to benefit only those Employees who are working on the workday immediately preceding a holiday. Employees who are not scheduled to work the ~~day Employees are permitted to leave early~~early release day, due to PTO ~~or~~, a 9/80 day off, taking their Flex Holiday or other reasons, are not entitled to the early release pay or any credit ~~or~~for future early release.

III. PROCEDURE

A. CalOptima Health will note holiday observances annually on its payroll schedule. In the event of a change to the published schedule, CalOptima Health will provide prompt notice to all Employees.

B. When a holiday falls on a regular nine (9) hour workday for a full-time non-exempt Employee on a 9/80 schedule pursuant to CalOptima Health Policy GA.8020: 9/80 Work Schedule, the Employee has the option of using one (1) hour of accrued PTO or making up the time if approved by their supervisor. For Employees on the 9/80 Work Schedule, should a holiday fall on an Employee's scheduled day off, the Employee will be permitted to take another day off in the same workweek.

C. Regular part-time Employees will receive pro-rated holiday hours based on their ~~budgeted~~assigned Full Time Equivalency (FTE), not to exceed eight (8) hours per holiday. For example, if a part-time Employee is assigned to a 0.75 FTE, they will receive six (6) hours for the holiday.

D. All regular, non-exempt~~, full-time~~ Employees who are eligible for paid holidays but who may be required to work on a holiday observed by CalOptima Health will receive Holiday Premium Pay in accordance with CalOptima Health Policy GA.8042: Supplemental Compensation. ~~If a regular, non-exempt part-time Employee is required to work a scheduled holiday, they will receive their regular base rate of pay for the holiday, in addition to their regular compensation for the hours of actual work performed.~~

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.8020: 9/80 Work Schedule
B. CalOptima Health Policy GA.8042: Supplemental Compensation

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
04/07/2016	Regular Meeting of the CalOptima Board of Directors
04/05/2018	Regular Meeting of the CalOptima Board of Directors

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12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
06/06/2024	Regular Meeting of the CalOptima Health Board of Directors
10/03/2024	Regular Meeting of the CalOptima Health Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2014	GA.8056	Paid Holidays	Administrative
Revised	04/07/2016	GA.8056	Paid Holidays	Administrative
Revised	04/05/2018	GA.8056	Paid Holidays	Administrative
Revised	02/01/2021	GA.8056	Paid Holidays	Administrative
Revised	12/01/2022	GA.8056	Paid Holidays	Administrative
Revised	06/06/2024	GA.8056	Paid Holidays	Administrative
Revised	10/03/2024	GA.8056	Paid Holidays	Administrative
Revised	08/01/2025	GA.8056	Paid Holidays	Administrative

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IX. GLOSSARY

Term	Definition
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 work schedule, one (1) calendar week will consist of forty-four (44) hours (four (4) nine (9)-hour days and one (1) eight (8)-hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9)-hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Fair Labor Standards Act (FLSA) Workweek.
Employee	For the purposes of this policy, employees include regular full-time and regular part-time CalOptima Health employees who are regularly scheduled to work twenty (20) or more hours per week.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.

For 20250904 BOD Review Only

Policy:	GA.8056
Title:	**Paid Holidays**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	04/01/2014
Revised Date:	08/01/2025
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20250904 BOD Review Only

I. PURPOSE

This policy establishes the paid holiday schedule for CalOptima Health Employees.

II. POLICY

A. The following holidays shall be observed by CalOptima Health:

1. New Year's Day
2. Martin Luther King Jr's Birthday
3. Lincoln's Birthday
4. Washington's Birthday
5. Memorial Day
6. Independence Day
7. Labor Day
8. Indigenous Peoples' Day
9. Veterans Day
10. Thanksgiving Day
11. Day after Thanksgiving
12. Christmas Day
13. One Flex Holiday (credited on January 1, of each calendar year)

B. To receive holiday pay, Employees must work or be paid for the regularly scheduled workdays preceding and following the CalOptima Health holiday.

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1. If a paid holiday occurs during the period an Employee is on a Leave of Absence (LOA), the Employee may be eligible for the holiday pay if Paid Time Off (PTO) is being used for the LOA the day before and the day after the holiday, and the holiday pay will be prorated based on the Employee's full-time or part-time status as it was in effect prior to the LOA. If a holiday falls on a day in which the Employee would have been regularly scheduled to work, the holiday will count against the Employee's LOA entitlement.

C. A holiday that falls on a Saturday or Sunday can be observed on the preceding Friday or the following Monday. Holiday observances will be noted on the annual payroll schedule. Employees will be provided with notice of any changes to the published schedule.

D. Flex Holiday

1. Eligibility

a. Current Employees in active status on December 31st are eligible to earn a maximum of one (1) Flex Holiday a maximum of eight (8) hours, (prorated for part-time employees based on approved schedule) each calendar year on January 1st.

2. Limits are imposed on the number of Flex Holiday hours that can be maintained in an Employee's Flex Holiday account. A maximum of twelve (12) hours, prorated based on scheduled work hours, may be maintained in an Employee's Flex Holiday account as of January 1st of each year. In the event that available Flex Holiday hours are not used by the last pay period of the calendar year, Employees may carry unused Flex Holiday hours into subsequent years and may accrue additional hours up to the maximum of eight (8) hours, prorated based on scheduled work hours. If an Employee reached the maximum amount of twelve (12) hours on January 1st, prorated based on scheduled work hours, the Employee will stop accruing Flex Holiday hours.

3. Flex Holiday hours are not eligible for annual cash out applicable to Paid Time Off (PTO) hours.

4. The Chief Executive Officer (CEO) may assign a specific date for the Flex Holiday for business reasons and/or needs. Assignment of the Flex Holiday will be announced in advance. Otherwise, Employees may take the Flex Holiday on any day elected by the Employee, subject to approval by the Employee's manager.

5. If an Employee separates from CalOptima Health and has unused Flex Holiday hours, the unused Flex Holiday hours will be paid out at the same time and in the same manner as unused PTO hours upon termination.

6. Employees on an approved leave of absence on December 31st will be eligible to receive a maximum of one (1) Flex Holiday (maximum of eight (8) hours, prorated based on scheduled work hours) upon their return to active status. If the Employee does not return to work after their approved leave of absence, and instead separates from employment with CalOptima Health, the Employee will not be eligible to receive the Flex Holiday.

E. Regular full-time and regular part-time Employees shall be paid their base rate of pay for the holidays specified in this Policy.

F. CalOptima Health may, in its discretion, amend the list of paid holidays and/or require an Employee to work on one or more of the observed holidays.

For 20250904 BOD Review Only

G. Holiday Early Out: From time to time, at the discretion of the CEO, the CEO, or their Designee, may authorize managers, at their discretion, to release Employees early, up to a maximum of two (2) hours, with pay, on the workday immediately preceding a holiday, as long as departments ensure critical areas are covered for the entire business day. The release of Employees early as provided herein is intended to benefit only those Employees who are working on the workday immediately preceding a holiday. Employees who are not scheduled to work the early release day, due to PTO, a 9/80 day off, taking their Flex Holiday or other reasons, are not entitled to the early release pay or any credit for future early release.

III. PROCEDURE

A. CalOptima Health will note holiday observances annually on its payroll schedule. In the event of a change to the published schedule, CalOptima Health will provide prompt notice to all Employees.

B. When a holiday falls on a regular nine (9) hour workday for a full-time non-exempt Employee on a 9/80 schedule pursuant to CalOptima Health Policy GA.8020: 9/80 Work Schedule, the Employee has the option of using one (1) hour of accrued PTO or making up the time if approved by their supervisor. For Employees on the 9/80 Work Schedule, should a holiday fall on an Employee's scheduled day off, the Employee will be permitted to take another day off in the same workweek.

C. Regular part-time Employees will receive pro-rated holiday hours based on their assigned Full Time Equivalency (FTE), not to exceed eight (8) hours per holiday. For example, if a part-time Employee is assigned to a 0.75 FTE, they will receive six (6) hours for the holiday.

D. All regular, non-exempt Employees who are eligible for paid holidays but who may be required to work on a holiday observed by CalOptima Health will receive Holiday Premium Pay in accordance with CalOptima Health Policy GA.8042: Supplemental Compensation.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.8020: 9/80 Work Schedule
B. CalOptima Health Policy GA.8042: Supplemental Compensation

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
04/07/2016	Regular Meeting of the CalOptima Board of Directors
04/05/2018	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
06/06/2024	Regular Meeting of the CalOptima Health Board of Directors
10/03/2024	Regular Meeting of the CalOptima Health Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2014	GA.8056	Paid Holidays	Administrative
Revised	04/07/2016	GA.8056	Paid Holidays	Administrative
Revised	04/05/2018	GA.8056	Paid Holidays	Administrative
Revised	02/01/2021	GA.8056	Paid Holidays	Administrative
Revised	12/01/2022	GA.8056	Paid Holidays	Administrative
Revised	06/06/2024	GA.8056	Paid Holidays	Administrative
Revised	10/03/2024	GA.8056	Paid Holidays	Administrative
Revised	08/01/2025	GA.8056	Paid Holidays	Administrative

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IX. GLOSSARY

Term	Definition
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 work schedule, one (1) calendar week will consist of forty-four (44) hours (four (4) nine (9)-hour days and one (1) eight (8)-hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9)-hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Fair Labor Standards Act (FLSA) Workweek.
Employee	For the purposes of this policy, employees include regular full-time and regular part-time CalOptima Health employees who are regularly scheduled to work twenty (20) or more hours per week.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.

For 20250904 BOD Review Only

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

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

Contacts

Michael Hunn, Chief Executive Officer, (714) 246-8570
Steve Eckberg, Chief Human Resources Officer, (657) 328-9053

Recommended Actions

1. Authorize the Chief Executive Officer to enter into contracts and/or contract amendments with existing vendors to provide group health insurance for CalOptima Health employees and eligible retirees (and their dependents) for Calendar Year (CY) 2026 in an amount not to exceed $37.0 million, which includes the following updates:

    a. Medical: Renew the current Blue Shield of California (Blue Shield) Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) and PPO Savings High Deductible Health Plan (HDHP) plans; Kaiser Permanente (Kaiser) HMO and Kaiser Senior Advantage health plans; AmWins Retiree Medicare Supplement Plan.

    b. Dental: Replace Blue Shield dental plans with Delta Dental plans, with enhanced benefits and more providers in-network.

    c. Vision: Renew the current VSP vision plan.

    d. Basic life, accidental death and dismemberment (ADD), short-term disability (STD) and long-term disability (LTD) insurance: Renew current New York Life basic life/ADD, STD and LTD insurance with no change in plan designs. Replace current individual Trustmark lines with New York Life Accident and critical illness lines on a group policy.

    e. Employee assistance program (EAP): Renew the current Aetna Resources for Living and Counseling Services EAP. Continue the current Registered Dietician consultations by Taylor Rickrode.

    f. Wellness program: Continue the current program with no change to proposed activities.

    g. Flexible spending accounts (FSA): Renew the current Wex FSA plan with no change in plan design.

    h. COBRA administration: Renew the current Wex plan with no changes.

    i. Parental leave program: Add parental leave program benefit effective January 1, 2026, through a contract with Parento.

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j. Pet insurance: Add pet insurance benefit effective January 1, 2026, through a contract with Pet Benefit Solutions.

k. No changes to all other plan options and benefit levels other than state and carrier-mandated changes, as well as those mandated by the Internal Revenue Service for the Health Savings Account (HSA) Qualified HDHP and the Dependent Care FSA.

l. As a result of the changes to the CY 2026 benefit renewal and employee contribution, an annual increase in total employer contributions for CY 2026 of approximately $32,000.

m. A continuation of employer contributions for CY 2026 in an estimated amount of $444,800 to fund the HSAs monthly for employees anticipated to enroll in the Blue Shield HDHP PPO.

2. Authorize the receipt and expenditures for CalOptima Health staff wellness programs of $75,000 in funding from Blue Shield for CY 2026.

Background

California Government Code section 53201 gives local public agencies, including CalOptima Health, the option of providing health and welfare benefits for the benefit of their officers, employees, and retired employees who elect to accept the benefits and who authorize the local agencies to deduct the premiums, dues, or other charges from their compensation. Government Code section 53200 provides that health and welfare benefits may include hospital, medical, surgical, dental, disability, group life, legal expense, and income protection insurance or benefits. From January 2025 through December 2027, CalOptima Health will be purchasing insurance through Alliant Insurance Services (Alliant), an insurance broker. CalOptima Health currently contracts with both Kaiser and Blue Shield to provide group health insurance coverage for all benefited employees and qualifying retirees. CalOptima Health also contracts with AmWins to provide Medicare supplemental coverage for qualifying Medicare eligible retirees and their dependents.

By statute, the Board of Directors (Board) may authorize payment of all, or such portion as it may elect, of premiums for these health and welfare benefits. CalOptima Health currently pays a portion of the premiums for health and welfare benefits for employees, eligible retired employees, and their eligible dependents. A summary of employer and employee contributions since CY 2020 is provided below.

- In CY 2020, there was an 8.0% increase in premium rates in the amount of $1,605,723, and CalOptima Health and employees shared the costs of the premium rate increases.

- In CY 2021, there was a 7.2% decrease in premium rates in the amount of $1,570,131. With rate caps for 2022 set as high as 12.0%, it was assumed the premium rates for CY 2022 would increase to such an extent that rates would essentially return to the same premium rates as CY 2020. As such, the contribution strategy adopted in 2020 for CY 2021 benefits was to hold employee contribution rates (no decrease or increase) steady for the two years when CalOptima Health would experience a decrease in premiums (CY 2021) and then an increase in premiums (plan year 2022).

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- As anticipated, in CY 2022 there was an increase in premium rates of 7.3% or $1,590,567, and CalOptima Health absorbed this premium increase, with no increase to employee contribution rates.

- To mitigate premium increases in CY 2023, CalOptima Health replaced the Cigna medical and dental plans with Blue Shield plans and absorbed the 9.3% increase in premium rates in the amount of $2,185,777, with no increase to employee contribution rates.

- To enhance recruitment and retention efforts during a period of inflation and competition in the labor market, in CY 2024, CalOptima Health absorbed the 7.9% increase in premium rates in the amount of $2,159,825, with no increase to employee contribution rates.

- In CY 2025, there was an overall increase of in premium rates of 10.6%. CalOptima Health absorbed the $3,437,974 increase in premium rates, with no increase to employee contribution rates.

Discussion

On behalf of CalOptima Health, Alliant negotiated for the renewal of CalOptima Health's health and welfare benefits for CY 2026. During pre-renewal strategy discussions, staff received prior year (CY 2024) health plan utilization updates and year-to-date loss ratio data for current medical (Blue Shield 99% loss ratio), dental (101% loss ratio) and vision plans (103% loss ratio). The loss ratio data reflected the losses CalOptima Health's insurers incurred from paying claims as a percentage of premiums earned in CY 2024.

CalOptima Health staff decided to maintain the existing medical plans for CY 2026, with no change to plan design other than those changes mandated by Internal Revenue Service limits. Based on employee feedback, Alliant conducted a full market analysis and presented competitive options from Delta Dental and MetLife for CalOptima Health's consideration. Delta Dental has a triple tier PPO network (PPO, Premier, and Out-of-Network) and has 89% in-network providers based on CalOptima Health's utilization compared to 67% with Blue Shield. As such, staff recommends the addition of Delta Dental and renewing the current Kaiser and Blue Shield medical plans, as well as VSP vision, New York Life Basic Life/ADD, STD, LTD, Accident and Critical Illness, Aetna Resources for Living EAP, and Wex FSA plans and COBRA administration, and adding Parento paid parental leave and voluntary pet insurance through Pet Benefits Solutions in CY 2026, resulting in a gross annualized premium increase of 3.2%, or $1,198,401 from CY 2025.

Cost of Benefits	**CY 2025***	**CY 2026****	**CY 2026 vs. CY 2025**
Active and Retiree Medical Insurance (Blue Shield, Kaiser, AmWins)	$32,633,247	$33,397,018	$763,771
Wellness Activities	$75,000	$75,000	$0
Wellness Funding	($75,000)	($75,000)	$0
Dental Insurance	$1,767,618	$1,831,163	$63,545
Vision Insurance	$289,102	$306,359	$17,257
Basic Life and ADD Insurance	$108,100	$108,100	$0
STD Insurance	$1,022,853	$1,022,853	$0

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Cost of Benefits	CY 2025*	CY 2026**	CY 2026 vs. CY 2025
LTD Insurance	$541,476	$541,476	$0
EAP with Counseling (Aetna Resources for Living)	$61,877	$63,250	$1,373
Registered Dietician	$21,000	$21,000	$0
HSA Employer Contribution	$444,800	$444,800	$0
Medical Stipends	$427,200	$427,200	$0
FSA Administration	$23,354	$23,354	$0
COBRA Administration	$8,905	$8,905	$0
One-time Implementation Credit (Delta Dental)	--	($10,000)	($10,000)
Parental Leave Program (Parento)	--	$362,455	$362,455
Total	**$37,349,530**	**$38,547,932**	**$1,198,401**

Notes:
Some figures may be slightly different due to rounding.
* Figures are based on census data [full-time equivalency (FTE) and plan enrollments] as of March 2025.
** Figures are based on census data [FTE and plan enrollments] as of April 2025 for Blue Shield, Delta Dental, VSP and EAP. For Kaiser, the figures are based on July 2025 census data. All other benefits listed are as of June 2025. They are subject to change after the 2026 Open Enrollment Period, FTE changes, and mid-year plan changes through March 2026.

CalOptima Health and employees will share the cost of the premium rate increases. In aggregate, employees will contribute approximately 10%, and CalOptima Health's contributions to the total group health and welfare benefits package will total $34,699,182 or 90% of the total benefit costs. Based on the recommendations above, the CY 2026 employer contributions are 0.1% or $31,775 higher than CY 2025, and the CY 2026 employee contributions are 41.6% or $1,116,626 higher than CY 2025. Using CY 2025 census data, the estimated costs are as shown in the table below and additional details are provided by benefit plan for CY 2026 in Attachment 2.

Contributions to Benefits	CY 2025	CY 2026	CY 2026 vs. CY 2025
CalOptima Health's Share	$34,667,407	$34,699,182	$31,775
Employees' Share	$2,682,123	$3,848,749	$1,166,626
Total	**$37,349,530**	**$38,547,932**	**$1,198,401**

CalOptima Health's and individual employee's share of healthcare premiums differ depending on the employee's elections. As set forth in Attachment 2, employer premium contributions for full-time employees range from 84.5% to 94.5%, and the premium contribution rates for employees and retirees range from 5.5% to 15.5%. The methodology used to calculate the employer and employee contributions is intended to aid management in attracting and retaining talented employees.

Medical
Blue Shield of California: For CY 2026, the Blue Shield HMO, PPO and HDHP Active and Early Retiree plans are being renewed with a 9.8% premium rate increase or $1,568,986 in additional premium cost. Blue Shield allowed the unbundling of the dental plans without impact to the medical plan

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negotiations. Telehealth service fees for preventive care were waived from the deductible on HDHP without impact to HSA due to the One Big Beautiful Bill Act.

Kaiser: Kaiser is being renewed with a 5% decrease for active and early retirees and an increase of 1.6% for the Senior Advantage HMO Plan for a combined reduction in premiums of $805,215. The proposed renewal action is driven by an overall 16% decrease in paid claims.

AmWins PPO: AmWins provides PPO supplemental coverage to Medicare-eligible retirees and dependents. Plan renewal will be released in September 2025. Currently, staff recommends that the employee/retiree contribution rates remain at the same level for CY 2026.

Wellness Funding: Blue Shield will provide a $75,000 wellness subsidy to assist in improving the health and wellness of CalOptima Health's employees, focusing on behavior change and health status improvement, and creating a health and wellness program strategy leading toward a culture of well-being. Blue Shield wellness funds may be used to reimburse CalOptima Health for employee health and wellness program expenses, including, but not limited to, educational workshops and employee wellness activities.

For CY 2026, the proposed wellness activities may include the following:

CY 2025 Wellness Program/Event/Activity	**Estimated Cost**
Wellness Month (Wellness activities)	$5,000
Health Education/Wellness Incentives	$5,000
Health & Fitness Video Library	$7,000
Early Detection Screenings	$35,000
Wellness App and Wellness Challenges	$8,000
Health & Wellness Fair	$15,000
Total	**$75,000**

Dental

Delta Dental: Blue Shield Dental HMO and PPO plans will be replaced with Delta Dental's DHMO and Delta's triple tier PPO network (PPO, Premier, and Out-of-Network option). Blue Shield proposed a renewal increase of 16.4% or $290,270 due to a loss ratio above 100% for the DPPO plan. In response to employee requests, staff proposes contracting services with a more comprehensive dental plan through Delta Dental.

Overall, Delta Dental has a triple tier PPO network and, in reviewing dental disruption, Blue Shield had 67.6% providers in-network compared to Delta Dental at 89.6% based on CalOptima Health's employee provider utilization data. Delta Dental's proposal presented at 3.6% above current, or $63,545 annualized, premium increase and includes a $10,000 one-time onboarding credit, a 24-month rate guarantee, and a 5% third year rate cap.

Vision

VSP**:** The VSP vision plans are coming out of a three-year rate guarantee, which expires on December 31, 2025. In 2022, Alliant negotiated a decrease on the core plan and added a buy-up option. CalOptima Health has over 100% loss ratio for each of the last three years (103%, 103% and 102%, respectively). VSP's underwriter made a concession with a 6% renewal increase or an annualized increase of $17,257,

which is a 3% reduction in the original proposed increase. CY 2026 rates are still below where they were set in CY 2020.

Other Ancillary Plans

New York Life & Disability:

Basic Life/ADD: The renewal has no rate change due to a rate guarantee through December 31, 2026.

Voluntary Life/ADD: New York Life will allow enrollment up to a guaranteed issue amount of $100,000 for the employee and $30,000 for the employee's spouse without review by underwriting. The renewal has no rate change due to a rate guarantee through December 31, 2026. Staff recommends adding additional voluntary lines with New York Life Accident and Critical Illness on a group policy to replace the individual Trustmark lines. This is a better benefit at a lower cost for employees. Employees will be eligible to continue the terminated Trustmark individual lines directly with the vendor.

Short-Term Disability and Long-Term Disability: The renewal has no rate change due to a rate guarantee through December 31, 2026.

Employee Assistance Program (EAP):

Aetna Resources for Living: The Aetna Resources for Living EAP and onsite counseling is coming out of a three-year rate guarantee. The negotiated renewal is 4.3% or $1,373 annualized with an option to maintain the new rates for three years. Staff proposes to continue the funding for on-site and virtual counseling in the amount of $21,000 due to the positive feedback from employees regarding this benefit.

Registered Dietician: Utilizing wellness funds provided by Blue Shield, registered dietician consultations were introduced in CY 2024. All appointments were filled within hours of launching the services. In response, staff contracted with Taylor Rickrode for additional consultation hours, which were still met with high employee demand. Due to the interest in and value of the on-site and virtual registered dietician consultations introduced in CY 2024, staff recommends continuing to fund on-site and virtual consultations in CY 2026 in the amount of $21,000.

Health Savings Account: CalOptima Health offers an HSA for employees enrolled in the HDHP medical plan. The minimum deductible amount for HDHPs is $1,700 for self-only coverage and $3,400 for family coverage. For CY 2026, staff recommends maintaining the current employer contribution to the HSA of $1,600 for self-only coverage and $3,200 for family coverage which aligns with the CY 2025 deductible limits. Assuming all employees currently in the plan continue this coverage, the annual amount will be $444,800.

Dependent Care FSA:

Effective January 1, 2026, Dependent Care FSA annual contribution limits are increasing per the One Big Beautiful Bill Act. The new annual contribution limit employees may set aside on a pre-tax basis would be increased from $5,000 to $7,500 per plan year (or from $2,500 to $3,750 if married filing separately). This is a voluntary employee election and there is no cost associated with the increase for CalOptima Health.

Medical Stipends: CalOptima Health offers a medical stipend of $100 per pay period (for 24 pay periods) as a cost saving measure to CalOptima Health and an incentive for employees who have

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medical coverage outside of CalOptima Health. Employees must submit proof of outside coverage to be eligible for this benefit.

Parental Leave Program: Staff recommends adding an employer-sponsored parental leave program through Parento. This program will provide white glove concierge support, including parent coaching, unlimited individual and group sessions, birth and parental leave plans, and support all stages of parenting. The contract effective date will be December 1, 2025, as the policy has a 30-day waiting period. For CY 2026, the new benefit will take effect on January 1, 2026. The estimated annual cost is $362,455 or $18.43 per enrollee per month. This program is non-concurrent, meaning it will work alongside STD and/or state programs to create a more necessary and flexible policy, which is fully insured. The benefit will offer eight (8) weeks of coverage at 75% of salary or a weekly reimbursement of up to $1,750.

Pet Insurance:
Staff recommends adding voluntary, employee-paid pet insurance, wellness, and pet discount program through Pet Benefit Solutions.

Staff Recommendations
For CY 2026, staff recommends using an aggregated 90/10 model for the division of CalOptima Health and employee/retiree contribution rates to continue ensuring that CalOptima Health remains competitive with market trends and meets its ongoing obligation to provide a comprehensive benefits package to attract and retain talent during a period of inflation and competitive labor market.

In the event employer contributions are materially different from the estimated amounts presented in this action due to plan enrollment and/or FTE changes, staff will return to the Board with additional recommendations.

Fiscal Impact
The estimated fiscal impact for group health insurance policies for CalOptima Health employees and retirees in CY 2026 is $34,699,182.

Funding for the period of January 1, 2026, through June 30, 2026, is a budgeted item. The Fiscal Year (FY) 2025-26 Operating Budget included $37.0 million for the period of July 1, 2025, through June 30, 2026.

Management will include funding for group health insurance policies and wellness benefits for the period of July 1, 2026, through December 31, 2026, in the CalOptima Health FY 2026-27 Operating Budget.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Entities Covered by the Recommended Action
2. CalOptima Health 2026 Renewal Executive Summary

/s/ Michael Hunn *08/28/2025*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Aetna Resources for Living EAP	10260 Meanley Drive	San Diego	CA	92131
Alliant Insurance Services	333 S. Hope Street, Suite 3650	Los Angeles	CA	90071
Amwins Group Benefits	50 Whitecap Dr.	North Kingstown	RI	02852
Blue Shield of California	100 N. Pacific Coast Hwy, 20th Floor	El Segundo	CA	90245
Delta Dental Of California	560 Mission Street Suite 1300	San Francisco	CA	94105
Kaiser Permanente	1851 E. First Street, Suite 1100	Santa Ana	CA	92705
New York Life Insurance Company	400 N. Brand Boulevard, 4th Floor	Glendale	CA	91203
Parento	251 Little Falls Drive	Wilmington	DE	19808
Pet Benefit Solutions	211 Boulevard of the Americas Suite 403	Lakewood	NJ	08701
VSP	333 Quality Drive	Rancho Cordova	CA	95670
WEX Health Inc	4321 20th Ave S	Fargo	ND	58103

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CalOptima Health 2026 Renewal Executive Summary

July 28, 2025

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Medical Renewals

Blue Shield of California

Blue Shield proposed an overall increase of +15.8% or $2,531,175 in additional premium for plan year 2026. The renewal calculation was reviewed and challenged by Alliant's service and underwriting team; it was negotiated down from 15.8% to 9.8%, an annualized savings of $962,188. The annualized premium increase to CalOptima Health for 2026 based on current enrollment is +$1,568,986. Blue Shield allowed the unbundling of the dental plans without impact to the medical negotiations. In addition, Alliant negotiated $75,000 in wellness subsidy.

Kaiser Permanente

Kaiser proposed renewal action is a -5% decrease on the active and early retiree HMO plan and a 1.6% increase on the Senior Advantage HMO plan, resulting in a combined reduction in premium of ($805,215). The proposed renewal action is driven an overall decrease in paid claims by -16%.

AmWins

The AmWins Group Retiree Medical and Prescription Drug Program will have the renewals released September 2025.

Medical Marketing

Given the Kaiser reduction, the Blue Shield renewal was approached with an Underwriting Challenge and No Bid strategy. The PRSIM request was pulled from the table once the No Bid Strategy was addressed.

Renewal Recommendation

Renew the current Blue Shield of CA plans, effective January 1, 2026, with no changes to the current plan options and benefit levels other than those mandated by the IRS for the HSA Qualified High-Deductible Health Plan, as well as those mandated by the state and carrier.
Telehealth service fees for preventive care waived from deductible on HDHP without impact to HSA due to One Big Beautiful Bill Act (OBBA).
CA new SB729 mandate requires coverage for fertility/infertility services for fully-insured medical plans.
Both Kaiser and Blue Shield modified weight loss medications not covered unless medically necessary for those Class III morbidly obese – they are not covered for those with BMI under 40
Renew the current Kaiser HMO (Active and Early Retirees) and Kaiser Senior Advantage plans with no changes in plan design, except state and carrier mandated noted changes.

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Ancillary Renewals

Dental Plans

The DPPO is again running above a 100% loss ratio – Blue Shield presented a +16.4%, +290,271 renewal between the DHMO and DPPO plan. Based on employee feedback a full market analysis was reviewed and presented competitive options with Delta Dental and MetLife.

Overall Delta Dental has a triple tier PPO network (PPO, Premier and Out-of-Network) and in reviewing dental disruption Blue Shield had 67.6% Providers In-Network compared to Delta Dental at 89.6% based on CalOptima's employee provider utilization data. Delta Dental's proposal presented +3.6% above current, +$63,545 annualized premium increase – includes $10,000 onboarding credit, 24-month rate guarantee and 5% rate cap third year. Note, there will be a variance on how Out-of-Network claims are processed, which will be based on a Maximum Allowable Charge vs. 90% of Usual & Customary. Overall access to providers will be significantly greater with Delta Dental.

Vision Plans

The VSP vision plans are coming out of a three-year rate guarantee, which expires on December 31, 2025. In 2022 Alliant negotiated a decrease on the core plan and added a buy-up option. CalOptima has over 100% loss ratio the last three years (103%, 103% and 102%). The underwriter did make a concession with a +6% renewal increase +$17,257 annualized increase. Rates are still below where they were set in 2020.

Renewal Recommendation

Transition dental to Delta Dental effective January 1, 2026, with +3.6% blended increase from current +63,545. This is a $226,276 savings from the Blue Shield dental renewal. Delta Dental provided a 24-month rate guarantee and 5% rate cap in year three, as well as a $10,000 onboarding credit. Delta Dental also addresses the dental network access concerns voiced by team members.
Renew vision Base and Buy-up plan options with VSP effective January 1, 2026, with no changes to the current plan options and benefit levels.

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Miscellaneous Recommendations

Life and Disability	The New York Life (NYL) life and disability plans are currently in a rate guarantee. NYL has agreed to partner with CalOptima for a one-time opportunity for a True Open Enrollment to allow employees to enroll in Voluntary Life Insurance up to Guarantee Issue of $100,000 for Employee coverage and $30,000 Voluntary Life Insurance Spousal coverage without medical underwriting questions due to the long-standing relationship. All other lines continue in a rate guarantee through December 31, 2026. Recommend adding additional Voluntary lines with New York Life Accident and Critical Illness lines on a group policy to replace the individual Trustmark lines. A better benefit at a lower cost for employees. Terminate the Trustmark individual lines.
Employee Assistance Program	The Aetna Resources for Living EAP and onsite counseling is coming out of three-year rate guarantee. The initial renewal was +6.1%, +$1,962. Negotiated renewal was reduced to +4.3%, +$1,373 annualized. An option to maintain the new rates for three years.
FSA & COBRA Administrator	WEX Health: The FSA & COBRA plan administration fees are renewing level for the following plan year. WEX Rate Guarantee will end December 31, 2026. Note: Dependent Care FSA increasing for the first time in decades from $5,000 to $7,500, due to One Big Beautiful Bill Act.(OBBA). Renewal Recommendation: Renew FSA and COBRA administration with WEX Health.
Employer HSA Contribution	Maintain the annual employer HSA contribution to $1,600 for single and $3,200 for family coverage. Front load the contributions the first paycheck in January 2026 and pro-rate the amount for new hires based on date of hire.
Employer Contribution	CalOptima Health to move to an aggregate 90/10 Employer/Employee cost share sharing in the 2026 renewal increase with the employees.
Medical Waiver Benefit	Keep the benefit amount level at $200 per Waived Employee per month with validation of other coverage.
Parento – 8 Week Parental Leave Program	Recommend adding parental leave program through Parento with white glove concierge support – parent coaching, unlimited individual and group sessions, birth and parental leave plans, supports all stages of parenting Contract effective date would need to be 12/1/2025 as the policy has a 30-day waiting period Year One, this would make benefits effective 1/1/2026 Annual Cost: $362,455 ($18.43 PEPM equivalent) Non-Concurrent Fully-insured eight (8) weeks 75% of salary, $1,750 weekly reimbursement
Pet Benefit Solutions	Recommend adding Voluntary pet insurance, wellness and pet discount program through Pet Benefit Solutions.

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2026 Renewal - Financial Summary

Alliant Insurance Services

Initial Renewal
- +5.4%
- +$2,035,449

Overall Negotiated Blue Shield
- +2.9%
- +$1,072,672

Adding Parento, Overall
- +3.8%
- +1,435,127

Negotiated Blue Shield with Delta Dental
- +2.3%
- +$845,946

Adding Parento Total Cost
- +3.2%
- +$1,198,401

Line of Coverage	EE Count	Current Cost	Initial Renewal	$ Δ	% Δ	Negotiated Renewal	$ Δ	% Δ	Option W/Delta Dental	$ Δ	% Δ
Medical HMO - Kaiser HMO - Actives	754	$16,021,172	$15,221,964	-$799,208	-5.0%	$15,221,964	-$799,208	-5.0%	$15,221,964	-$799,208	-5.0%
Medical HMO - Kaiser HMO - Early Retirees	4	$166,356	$158,050	-$8,306	-5.0%	$158,050	-$8,306	-5.0%	$158,050	-$8,306	-5.0%
Medical HMO - KPSA	25	$144,348	$146,647	$2,299	1.6%	$146,647	$2,299	1.6%	$146,647	$2,299	1.6%
Medical HMO - AmWins Medicare	35	$291,336	Pending $291,336	$0	0.0%	Pending $291,336	$0	0.0%	Pending $291,336	$0	0.0%
Medical HMO - Blue Shield Full HMO	356	$8,113,153	$9,395,839	$1,282,686	15.8%	$8,908,241	$795,088	9.8%	$8,908,241	$795,088	9.8%
Medical HMO - Blue Shield Trio HMO	180	$3,421,444	$3,962,365	$540,921	15.8%	$3,756,749	$335,305	9.8%	$3,756,749	$335,305	9.8%
Medical PPO - Blue Shield PPO	3	$96,333	$111,563	$15,230	15.8%	$105,773	$9,441	9.8%	$105,773	$9,441	9.8%
Medical HDHP - Blue Shield HDHP with HSA	178	$4,379,106	$5,071,443	$692,337	15.8%	$4,808,259	$429,153	9.8%	$4,808,259	$429,153	9.8%
Dental HMO - Blue Shield DHMO	331	$110,119	$128,195	$18,075	16.4%	$128,195	$18,075	16.4%	Delta Dental DHMO $110,119	$0	0.0%
Dental PPO - Blue Shield DPPO	1298	$1,657,499	$1,929,694	$272,196	16.4%	$1,929,694	$272,196	16.4%	Delta Dental DPPO $1,721,044	$63,545	3.8%
Vision - VSP	1599	$289,102	$306,359	$17,257	6.0%	$306,359	$17,257	6.0%	$306,359	$17,257	6.0%
Basic Life and AD&D - New York Life	1640	$108,100	Rate Guarantee $108,100	$0	0.0%	Rate Guarantee $108,100	$0	0.0%	Rate Guarantee $108,100	$0	0.0%
Short Term Disability - New York Life	1641	$1,022,853	Rate Guarantee $1,022,853	$0	0.0%	Rate Guarantee $1,022,853	$0	0.0%	Rate Guarantee $1,022,853	$0	0.0%
Long Term Disability - New York Life	1641	$541,476	Rate Guarantee $541,476	$0	0.0%	Rate Guarantee $541,476	$0	0.0%	Rate Guarantee $541,476	$0	0.0%
Employee Assistance Program - Aetna RFL	1635	$32,177	$34,139	$1,962	6.1%	$33,550	$1,373	4.3%	$33,550	$1,373	4.3%
Employee Assistance Program - Aetna Counseling Services	1635	$50,700	$50,700	$0	0.0%	$50,700	$0	0.0%	$50,700	$0	0.0%
COBRA - WEX	1649	$8,905	Rate Guarantee $8,905	$0	0.0%	Rate Guarantee $8,905	$0	0.0%	Rate Guarantee $8,905	$0	0.0%
Flexible Spending Account - WEX	586	$23,354	Rate Guarantee $23,354	$0	0.0%	Rate Guarantee $23,354	$0	0.0%	Rate Guarantee $23,354	$0	0.0%
HSA Funding	178	$444,800	$444,800	$0	0.0%	$444,800	$0	0.0%	$444,800	$0	0.0%
Medical Waiver Funding	178	$427,200	$427,200	$0	0.0%	$427,200	$0	0.0%	$427,200	$0	0.0%
TOTAL ANNUAL PREMIUM		**$37,349,530**	**$39,384,980**	**$2,035,449**	**5.4%**	**$38,422,203**	**$1,072,672**	**2.9%**	**$38,195,477**	**$845,946**	**2.3%**
*Blue Shield Wellness Stipend $75,000											
One Time Implementation Credit									**$10.000**	**$10.000**	
Ongoing Technology Credit											
PARENTO - 8 Week Parental Leave Program						**$362,455**	**$362,455**		**$362,455**	**$362,455**	
ANNUALIZED PREMIUM LESS CREDITS						**$38,784,658**	**$1,435,127**	**3.8%**	**$38,547,932**	**$1,198,401**	**3.2%**

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CalOptima Health-Recommended Employer Contributions 2025

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2026 Recommended ER Contributions: Medical Plans

Alliant Insurance Services

Medical:

- Kaiser Active/Early Retirees
- Kaiser Senior Advantage
- AmWins (renewal pending)

Employee Contributions		2025 Current Contributions				2026 Renewal Contributions 90/10 Aggregate Split					
		Total	ER Cost	EE Cost	EE %	Total	ER Cost	EE Cost	EE %	EE Cost Δ	EE % Variance
Kaiser HMO - Actives	Lives										
EE Only	274	$889.36	$830.79	$58.57	6.6%	$844.99	$753.30	$91.69	10.9%	$33.12	4.3%
EE + Spouse	97	$1,778.72	$1,661.58	$117.14	6.6%	$1,689.98	$1,489.27	$200.71	11.9%	$83.57	5.3%
EE + Child(ren)	148	$1,689.77	$1,578.49	$111.28	6.6%	$1,605.48	$1,424.12	$181.36	11.3%	$70.08	4.7%
EE + Family	235	$2,845.92	$2,658.49	$187.43	6.6%	$2,703.96	$2,417.18	$286.78	10.6%	$99.35	4.0%
Annual Premium	754	$16,021,172	$14,966,057	$1,055,115		$15,221,964	$13,556,045	$1,665,918			
Kaiser HMO - Early Retirees											
EE Only	0	$1,332.99	$1,274.42	$58.57	4.4%	$1,266.43	$1,174.74	$91.69	7.2%	$33.12	2.8%
EE + Spouse	2	$2,665.98	$2,548.84	$117.14	4.4%	$2,532.86	$2,332.15	$200.71	7.9%	$83.57	3.5%
EE + Child(ren)	0	$2,532.66	$2,421.38	$111.28	4.4%	$2,406.21	$2,224.85	$181.36	7.5%	$70.08	3.1%
EE + Family	2	$4,265.53	$4,078.10	$187.43	4.4%	$4,052.57	$3,765.79	$286.78	7.1%	$99.35	2.7%
Annual Premium	4	$166,356	$159,047	$7,310		$158,050	$146,351	$11,700			
Kaiser KPSA											
EE Only on Medicare	10	$207.81	$185.72	$22.09	10.6%	$218.28	$196.19	$22.09	10.1%	$0.00	-0.5%
EE + Spouse both on Medicare	13	$415.62	$371.44	$44.18	10.6%	$436.56	$392.38	$44.18	10.1%	$0.00	-0.5%
EE on Medicare + Spouse Non-Medicare	0	$1,540.80	$1,430.96	$109.84	7.1%	$1,484.71	$1,374.87	$109.84	7.4%	$0.00	0.3%
EE on Medicare + Child Non-Medicare	1	$1,407.48	$1,306.41	$101.07	7.2%	$1,358.06	$1,256.99	$101.07	7.4%	$0.00	0.3%
EE on Medicare+Spouse Non-Medicare+Child Non-Medicare	1	$3,140.35	$2,925.20	$215.15	6.9%	$3,004.42	$2,789.27	$215.15	7.2%	$0.00	0.3%
Annual Premium	25	$144,348	$131,009	$13,338		$146,647	$133,308	$13,338			
AmWins Medicare											
EE Only on Medicare	20	$485.56	$407.55	$78.01	16.1%	$485.56	$407.55	$78.01	16.1%	$0.00	0.0%
EE + Spouse both on Medicare	15	$971.12	$794.22	$176.90	18.2%	$971.12	$794.22	$176.90	18.2%	$0.00	0.0%
Annual Premium	35	$291,336	$240,772	$50,564		$291,336	$240,772	$50,564			

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2026 Recommended ER Contributions: Medical Plans

Alliant Insurance Services

Medical:

- Blue Shield Plans (Trio, Access+, Traditional PPO, HDHP w/HSA)
- HSA Funding
- Medical Waivers

		Total	ER Cost	EE Cost	EE %	Total	ER Cost	EE Cost	EE %	EE Cost Δ	EE % Variance
Blue Shield Full HMO											
EE Only	113	$927.86	$869.29	$58.57	6.3%	$1,018.79	$927.10	$91.69	9.0%	$33.12	2.7%
EE + Spouse	46	$2,031.06	$1,913.92	$117.14	5.8%	$2,230.10	$2,029.39	$200.71	9.0%	$83.57	3.2%
EE + Child(ren)	88	$1,835.24	$1,723.96	$111.28	6.1%	$2,015.09	$1,833.73	$181.36	9.0%	$70.08	2.9%
EE + Family	109	$2,902.00	$2,714.57	$187.43	6.5%	$3,186.40	$2,899.62	$286.78	9.0%	$99.35	2.5%
Annual Premium	356	$8,113,153	$7,606,401	$506,751		$8,908,241	$8,106,493	$801,748			
Blue Shield Trio HMO											
EE Only	62	$744.81	$726.09	$18.72	2.5%	$817.80	$772.82	$44.98	5.5%	$26.26	3.0%
EE + Spouse	22	$1,630.32	$1,583.08	$47.24	2.9%	$1,790.09	$1,691.64	$98.45	5.5%	$51.21	2.6%
EE + Child(ren)	24	$1,473.14	$1,430.47	$42.67	2.9%	$1,617.51	$1,528.55	$88.96	5.5%	$46.29	2.6%
EE + Family	72	$2,329.44	$2,261.06	$68.38	2.9%	$2,557.73	$2,417.05	$140.68	5.5%	$72.30	2.6%
Annual Premium	180	$3,421,444	$3,323,680	$97,764		$3,756,749	$3,550,125	$206,624			
Blue Shield PPO											
EE Only	2	$1,574.60	$1,374.48	$200.12	12.7%	$1,728.91	$1,460.93	$267.98	15.5%	$67.86	2.8%
EE + Spouse	0	$3,410.48	$2,933.99	$476.49	14.0%	$3,744.71	$3,164.28	$580.43	15.5%	$103.94	1.5%
EE + Child(ren)	0	$3,083.88	$2,652.91	$430.97	14.0%	$3,386.10	$2,861.25	$524.85	15.5%	$93.88	1.5%
EE + Family	1	$4,878.51	$4,163.75	$714.76	14.7%	$5,356.60	$4,526.33	$830.27	15.5%	$115.51	0.8%
Annual Premium	3	$96,333	$82,952	$13,380		$105,773	$89,378	$16,395			
Blue Shield HDHP											
EE Only	78	$1,131.30	$1,027.65	$103.65	9.2%	$1,242.17	$1,086.90	$155.27	12.5%	$51.62	3.3%
EE + Spouse	31	$2,375.47	$2,083.09	$292.38	12.3%	$2,608.27	$2,282.24	$326.03	12.5%	$33.65	0.2%
EE + Child(ren)	25	$2,149.01	$1,884.47	$264.54	12.3%	$2,359.61	$2,064.66	$294.95	12.5%	$30.41	0.2%
EE + Family	44	$3,393.62	$2,864.95	$528.67	15.6%	$3,726.19	$3,197.52	$528.67	14.2%	$0.00	-1.4%
Annual Premium	178	$4,379,106	$3,814,828	$564,278		$4,808,259	$4,174,020	$634,239			
HSA Funding											
EE Only	78	$1,600.00	$1,600.00	$0.00	0.0%	$1,600.00	$1,600.00	$0.00	0.0%	$0.00	0.0%
EE + Dependents	100	$3,200.00	$3,200.00	$0.00	0.0%	$3,200.00	$3,200.00	$0.00	0.0%	$0.00	0.0%
Annual Premium	178	$444,800	$444,800	$0		$444,800	$444,800	$0			
Medical Waiver											
EE's Waiving Coverage	178	$200.00	$200.00	$0.00	0.0%	$200.00	$200.00	$0.00	0.0%	$0.00	0.0%
Annual Premium		$427,200	$427,200	$0.00	0.0%	$427,200	$427,200	$0.00	0.0%		
MEDICAL TOTAL	**1,535**	**$33,505,247**	**$31,196,746**	**$2,308,500**	**6.9%**	**$34,269,018**	**$30,868,492**	**$3,400,526**	**9.9%**		
DOLLAR CHANGE FROM CURRENT						**$763,771**	**-$328,255**	**$1,092,026**			
PERCENT CHANGE FROM CURRENT						**2.3%**	**-1.1%**	**47.3%**			

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2026 Recommended ER Contributions: Ancillary Plans

Alliant Insurance Services

Ancillary:

- Blue Shield Dental Plans (DHMO, DPPO) – Transition to Delta Dental (Recommended)
- Vision
- Life and DI

Employee Contributions		Total	ER Cost	EE Cost	EE %	Total	ER Cost	EE Cost	EE %	EE Cost Δ	EE % Variance
Blue Shield Dental PPO	**Lives**						Delta Dental				
EE Only	441	$45.34	$40.14	$5.20	11.5%	$47.08	$40.14	$6.94	14.7%	$1.74	3.3%
EE + Spouse	219	$90.09	$74.37	$15.72	17.4%	$93.54	$74.37	$19.17	20.5%	$3.45	3.0%
EE + Child(ren)	224	$115.72	$95.52	$20.20	17.5%	$120.16	$95.52	$24.64	20.5%	$4.44	3.1%
EE + Family	414	$175.07	$143.53	$31.54	18.0%	$181.78	$143.53	$38.25	21.0%	$6.71	3.0%
Annual Premium	1298	$1,657,499	$1,377,680	$279,819		$1,721,044	$1,377,680	$343,364			
Blue Shield DHMO							Delta Dental				
EE Only	129	$12.37	$12.37	$0.00	0.0%	$12.37	$12.37	$0.00	0.0%	$0.00	0.0%
EE + Spouse	49	$24.55	$24.55	$0.00	0.0%	$24.55	$24.55	$0.00	0.0%	$0.00	0.0%
EE + Child(ren)	57	$31.54	$31.54	$0.00	0.0%	$31.54	$31.54	$0.00	0.0%	$0.00	0.0%
EE + Family	96	$47.71	$47.71	$0.00	0.0%	$47.71	$47.71	$0.00	0.0%	$0.00	0.0%
Annual Premium	331	$110,119	$110,119	$0		$110,119	$110,119	$0			
VSP Vision (Core)											
EE Only	308	$6.71	$6.71	$0.00	0.0%	$7.11	$7.11	$0.00	0.0%	$0.00	0.0%
EE + Spouse	114	$10.42	$9.42	$1.00	9.6%	$11.04	$10.04	$1.00	9.1%	$0.00	-0.5%
EE + Child(ren)	132	$10.85	$9.35	$1.50	13.8%	$11.50	$10.00	$1.50	13.0%	$0.00	-0.8%
EE + Family	228	$17.37	$15.37	$2.00	11.5%	$18.41	$16.41	$2.00	10.9%	$0.00	-0.7%
Annual Premium	782	$103,765	$94,549	$9,216		$109,967	$100,751	$9,216			
VSP Vision (Buy-Up)											
EE Only	283	$11.21	$6.71	$4.50	40.1%	$11.88	$6.71	$5.17	43.5%	$0.67	3.4%
EE + Spouse	156	$17.41	$9.42	$7.99	45.9%	$18.45	$9.42	$9.03	48.9%	$1.04	3.0%
EE + Child(ren)	130	$18.13	$9.35	$8.78	48.4%	$19.21	$9.35	$9.86	51.3%	$1.08	2.9%
EE + Family	248	$29.03	$15.37	$13.66	47.1%	$30.76	$15.37	$15.39	50.0%	$1.73	3.0%
Annual Premium	817	$185,337	$100,749	$84,588		$196,392	$100,749	$95,644			
NYL Life and Disability							Rate Guaramtee				
Basic Life and AD&D	1640	$108,100	$108,100	$0.00	0.0%	$108,100	$108,100	$0.00	0.0%	$0.00	0.0%
Short Term Disability	1641	$1,022,853	$1,022,853	$0.00	0.0%	$1,022,853	$1,022,853	$0.00	0.0%	$0.00	0.0%
Long Term Disability	1641	$541,476	$541,476	$0.00	0.0%	$541,476	$541,476	$0.00	0.0%	$0.00	0.0%

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2026 Recommended ER Contributions: Ancillary Plans

Alliant Insurance Services

Medical:

- Aetna RFL (EAP) and Counseling services
- WEX Administrative fees
- Contribution Illustrated with Proposed Parento Paid Leave Program ($18.43 PEPM equivalent)

Employee Contributions		Total	ER Cost	EE Cost	EE %	Total	ER Cost	EE Cost	EE %	EE Cost Δ	EE % Variance
Employee Assistance Program (EAP)											
Aetna RFL	1635	$1.64	$1.64	$0.00	0.0%	$1.71	$1.71	$0.00	0.0%	$0.00	0.0%
		$32,177	$32,177	$0	0.0%	$33,550	$33,550	$0	0.0%	$0.00	0.0%
Aetna Couseling Services	1635	$50,700	$50,700	$0	0.0%	$50,700	$50,700	$0	0.0%	$0.00	0.0%
WEX Annual Administrative Fees											
COBRA	1649	$8,905	$8,905	$0	0.0%	$8,905	$8,905	$0	0.0%	$0.00	0.0%
Flexible Spending Accounts	586	$23,354	$23,354	$0	0.0%	$23,354	$23,354	$0	0.0%	$0.00	0.0%
Ancillary Total		**$3,844,284**	**$3,470,661**	**$373,623**	**9.7%**	**$3,926,459**	**$3,478,236**	**$448,223**	**11.4%**		
GRAND TOTAL (Medical and Ancillary):		**$37,349,530**	**$34,667,407**	**$2,682,123**	**7.2%**	**$38,195,477**	**$34,346,727**	**$3,848,749**	**10.1%**		
DOLLAR CHANGE FROM CURRENT						**$845,946**	**-$320,680**	**$1,166,626**			
PERCENT CHANGE FROM CURRENT						**2.3%**	**-0.9%**	**43.5%**			
DELTA DENTAL ONE-TIME CREDIT						**-$10,000**	**-$10,000**	**$0**			
PARENTO - 8 WEEK LEAVE						**$362,455**	**$362,455**	**$0**			
GRAND TOTAL (Medical and Ancillary with PARETO):						**$38,547,932**	**$34,699,182**	**$3,848,749**	**10.0%**		
DOLLAR CHANGE FROM CURRENT						**$1,198,401**	**$31,775**	**$1,166,626**			
PERCENT CHANGE FROM CURRENT						**3.2%**	**0.1%**	**43.5%**			

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Disclosures

Alliant embraces a policy of transparency with respect to its compensation from insurance transactions. Details on our compensation policy, including the types of income that Alliant may earn on a placement, are available on our website at www.alliant.com. For a copy of our policy or for any inquiries regarding compensation issues pertaining to your account you may also contact us at: Alliant Insurance Services, Inc., Attention: General Counsel, 701 B Street, 6th Floor, San Diego, CA 92101.

Plans are rates presented are generally effective 01/01/2026 through 12 31 2026.
Rates quoted assume current employer contribution levels and participation levels unless otherwise stated. Final rates will be based on final enrollment underwriting. Updated claims experience or other information may be required to finalize rates. If group demographics, enrollment levels or employer contributions change, rates may change, or the quote may be withdrawn.

In general, employees must be actively at work on the effective date of the plan. When implementing new coverage, employees who are not actively at work will not be covered under the plan until they return to active state. It may be possible to waive the actively at work provision.
This proposal should not be interpreted as inclusive of all plan provisions and limitations. For further details, refer to the insurance carrier proposals and carrier plan documents. Benefit coverage and eligibility provisions for fully insured health plans may vary from state to state, based on state mandates. Illustrated enrollment is based on the information provided (employee census, current premium statement and or carrier renewal).
Coverage is not in effect until it is approved by the insurance carrier's underwriter.

Analyzing insurers' over-all performance and financial strength is a task that requires specialized skills and in-depth technical understanding of all aspects of insurance company finances and operations. Insurance brokerages such as Alliant typically rely upon rating agencies for this type of market analysis. A.M. Best has been an industry leader in this area for many decades, utilizing a combination of quantitative and qualitative analysis of the information available in formulating their ratings. Alliant's standard protocol is to only place coverage with carriers with no less than an "A-"- rating from A.M. Best. However, where Alliant determines that it is prudent to consider coverage with a lower rated carrier, the financial rating of the carrier is to be disclosed to the client. Should Alliant become aware of a carrier's rating dropping below "A-" mid-policy period we will review and advise you of the situation and consider if an alternative carrier can be reasonably provided prior to renewal.
A.M. Best has an extensive database of nearly 6,000 Life/Health, Property Casualty and International companies. You can visit them at www.ambest.com.

Enrollments based on:
Kaiser July Kaiser enrollment report with the KPSA update renewal
Blue Shield April group census
Delta Dental April group census
VSP April group census
Life and Disability June NY Life invoice
EAP April group census
Wex June Invoice

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

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

Contact

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

Recommended Actions

Appoint the following individual to the Provider Advisory Committee:

a. Jonathan Megerian MD, Ph.D, FAAP, as a Physician Representative for a term ending June 30, 2028.

Background

The CalOptima Health Board of Directors (Board) established the Provider Advisory Committee (PAC) by resolution on February 14, 1995, to provide input to the Board. The PAC is comprised of fifteen voting members who each serve three-year terms with the exception of one standing seat for the representative from the Orange County Health Care Agency. The Board is responsible for the appointment of all PAC members.

Discussion

CalOptima Health staff conducted comprehensive outreach, including sending notifications to community-based organizations (CBOs), conducting targeted community outreach to agencies and CBOs serving the various open positions on the PAC, and posting recruitment materials on CalOptima Health's website and social media sites.

The PAC Nominations Ad Hoc Subcommittee, comprised of PAC Vice-Chair Gio Corzo and members Andrew Inglis, M.D., and Jena Jensen, reviewed the application and presented their recommendation at the August 14, 2025, PAC meeting. The ad hoc subcommittee formally requested that the PAC recommend Dr. Megerian for appointment as a Physician Representative and to forward the recommendation to the Board for consideration and appointment at its September 4, 2025, meeting.

The recommended PAC candidate for the open position is as follows:

Physician Representative

Jonathan Megerian, MD, Ph.D, FAAP

Dr. Megerian is the Clinical Director of the Thompson Autism and Neurodevelopment Center at Rady Children's Hospital of Orange County. He earned his medical degree from Northwestern University Medical School and is board-certified in pediatrics, psychiatry, and neurology, with a specialization in neurology and child neurology. Over 60% of his patients have neurodevelopmental disabilities and are part of the CalOptima Health population.

Fiscal Impact

There is no fiscal impact.

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Rationale for Recommendation

As stated in policy AA.1219b, the PAC established a Nominations Ad Hoc Subcommittee to review potential candidates for vacancies on the PAC. The PAC at its August 14, 2025, joint meeting with the Member Advisory Committee approved the Nominations Ad Hoc Subcommittee's recommendation. The PAC forwards the recommended candidate to the Board for consideration and appointment.

Concurrence

Provider Advisory Committee Nominations Ad Hoc Subcommittee
Provider Advisory Committee
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

None

/s/ Michael Hunn *08/28/2025*
Authorized Signature **Date**

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CalOptima Health

Financial Summary
July 31, 2025

Board of Directors Meeting

September 4, 2025

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

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

Financial Highlights
July 2025

July 2025	Actual	Budget	$ Variance	% Variance
Member Months	904,278	906,467	(2,189)	(0.2%)
Revenues	396,458,146	399,374,664	(2,916,518)	(0.7%)
Medical Expenses	366,713,502	370,870,900	4,157,398	1.1%
Administrative Expenses	20,527,877	25,599,842	5,071,965	19.8%
Operating Margin	**9,216,767**	**2,903,922**	**6,312,845**	**217.4%**
Non-Operating Income (Loss)				
Net Investment Income/Expense	7,917,132	8,333,340	(416,208)	(5.0%)
Community Reinvestment	(2,548,617)	-	(2,548,617)	(100.0%)
Other Income/Expense	(140,313)	(138,610)	(1,703)	(1.2%)
Total Non-Operating Income (Loss	**5,228,202**	**8,194,730**	**(2,966,528)**	**(36.2%)**
Change in Net Assets	**14,444,969**	**11,098,652**	**3,346,317**	**30.2%**
Medical Loss Ratio	*92.5%*	*92.9%*	*(0.4%)*	
Administrative Loss Ratio	*5.2%*	*6.4%*	*1.2%*	
Operating Margin Ratio	*2.3%*	*0.7%*	*1.6%*	
Total Operating	*100.0%*	*100.0%*		
**Adjusted MLR*	*88.1%*	*88.5%*	*(0.4%)*	
**Adjusted ALR*	*5.2%*	*6.4%*	*1.2%*	

*Adjusted MLR/ALR excludes estimated Board-approved Provider Rate increases and Directed Payments, but includes costs associated with CalOptima Health's Digital Transformation Strategy (DTS) budget.

CalOptima Health

FY 2025-26: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) July 2025: $14.4 million, favorable to budget $3.3 million or 30.2% driven by favorable Administrative Expenses

- Enrollment
  - MTD: 904,278 members, unfavorable to budget 2,189 or 0.2%

CalOptima Health

FY 2025-26: Management Summary (cont.)

- Revenue
  - MTD: $396.5 million, unfavorable to budget $2.9 million or 0.7% driven by:
    - $1.9 million in OneCare (OC) Line of Business (LOB) due to lower than anticipated Risk Adjustment Factor (RAF)
    - $1.0 million in MC LOB due to unfavorable volume variance

FY 2025-26: Management Summary (cont.)

- Medical Expenses
  - MTD: $366.7 million, favorable to budget $4.2 million or 1.1% driven by:
    - Medical Management favorable to budget $3.5 million due to timing of expenses
    - Provider Capitation favorable to budget $2.4 million due to lower enrollment
- Administrative Expenses
  - MTD: $20.5 million, favorable to budget $5.1 million or 19.8% due to timing of administrative expense activities

CalOptima Health

FY 2025-26: Management Summary (cont.)

- Non-Operating Income (Loss)
  - MTD: $5.2 million, unfavorable to budget $3.0 million or 36.2% due primarily to $2.5 million of accrued Community Reinvestment liabilities

FY 2025-26: Key Financial Ratios

- Medical Loss Ratio (MLR)

		Actual	Budget	Variance (%)
MTD	MLR	92.5%	92.9%	(0.4%)
	Adjusted MLR*	88.1%	88.5%	(0.4%)

- Administrative Loss Ratio (ALR)

		Actual	Budget	Variance (%)
MTD	ALR	5.2%	6.4%	1.2%
	Adjusted ALR*	5.2%	6.4%	1.2%

* Adjusted MLR/ALR excludes estimated Board-approved Provider Rate Increases and Directed Payments, but include costs associated with DTS.

CalOptima Health

FY 2025-26: Key Financials Ratios (cont.)

- Balance Sheet Ratios
  - Current ratio*: 1.8
  - Board Designated Reserve level: 3.77
  - Statutory Designated Reserve level: 1.02
  - Net-position: $2.8 billion, including required TNE of $129.3 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations.

Enrollment Summary: July 2025

	July 2025			
Enrollment (by Aid Category)	**Actual**	**Budget**	**$ Variance**	**% Variance**
SPD	152,402	147,168	5,234	3.6%
TANF Child	257,426	260,147	(2,721)	(1.0%)
TANF Adult	128,566	130,415	(1,849)	(1.4%)
LTC	2,600	2,513	87	3.5%
MCE	335,621	338,880	(3,259)	(1.0%)
WCM	9,164	9,120	44	0.5%
Medi-Cal Total	**885,779**	**888,243**	**(2,464)**	**(0.3%)**
OneCare	**17,971**	**17,695**	**276**	**1.6%**
PACE	**528**	**529**	**(1)**	**(0.2%)**
MSSP*	**553**	**558**	**(5)**	**(0.9%)**
CalOptima Health Total	**904,278**	**906,467**	**(2,189)**	**(0.2%)**

*MSSP enrollment is included in Medi-Cal total.

CalOptima Health

Consolidated Revenue & Expenses: July 2025 MTD

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	885,779	17,971	528	553		904,278
REVENUES						
Capitation Revenue	$ 355,958,648	$ 35,505,096	$ 4,742,424	$ 251,978	$ -	$ 396,458,146
Total Operating Revenue	**355,958,648**	**35,505,096**	**4,742,424**	**251,978**	**-**	**396,458,146**
MEDICAL EXPENSES						
Provider Capitation	113,767,195	14,756,132				128,523,327
Professional. Facility & Ancillary Claims	143,443,310	7,105,399	1,988,286			152,536,996
MLTSS	48,971,239		9,367	42,072		49,022,678
Prescription Drugs		10,815,996	569,433			11,385,430
Case Mgmt & Other Medical	20,922,067	2,685,241	1,442,423	195,341		25,245,072
Total Medical Expenses	**327,103,811**	**35,362,768**	**4,009,510**	**237,413**	**-**	**366,713,502**
Medical Loss Ratio	*91.9%*	*99.6%*	*84.5%*	*94.2%*	*0.0%*	*92.5%*
GROSS MARGIN	**28,854,837**	**142,327**	**732,914**	**14,565**	**-**	**29,744,644**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	11,936,021	1,015,914	186,943	105,547	53,097	13,297,522
Non-Salary Operating Expenses	2,854,078	420,599	92,343	1,457	50,315	3,418,792
Depreciation & Amortization	804,078		886			804,964
Other Operating Expenses	2,472,439	82,027	7,893	5,399		2,567,757
Indirect Cost Allocation, Occupancy	(767,028)	1,181,620	16,670	7,580		438,842
Total Administrative Expenses	**17,299,587**	**2,700,160**	**304,735**	**119,982**	**103,413**	**20,527,877**
Administrative Loss Ratio	*4.9%*	*7.6%*	*6.4%*	*47.6%*	*0.0%*	*5.2%*
Operating Income/(Loss)	**11,555,251**	**(2,557,832)**	**428,179**	**(105,418)**	**(103,413)**	**9,216,767**
Investments and Other Non-Operating	(2,547,016)					5,228,202
CHANGE IN NET ASSETS	**$ 9,008,235**	**$ (2,557,832)**	**$ 428,179**	**$ (105,418)**	**$ (103,413)**	**$ 14,444,969**
BUDGETED CHANGE IN NET ASSETS	5,389,487	(1,859,310)	219,283	(123,362)	(722,176)	11,098,653
Variance to Budget - Fav/(Unfav)	$ 3,618,748	$ (698,522)	$ 208,896	$ 17,944	$ 618,763	$ 3,346,316

CalOptima Health

Balance Sheet: As of July 2025

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$373,963,314	Accounts Payable	$105,746,041
Short-term Investments	1,464,311,276	Medical Claims Liability	1,048,281,485
Capitation Receivable	518,034,478	Accrued Payroll Liabilities	25,282,450
Receivables - Other	89,705,884	Deferred Revenue	15,146,239
Prepaid Expenses	13,520,101	Other Current Liabilities	-
Total Current Assets	**2,459,535,052**	Capitation and Withholds	158,732,484
		Total Current Liabilities	**1,353,188,699**
Capital Assets		**Other Liabilities**	
Capital Assets	189,230,387	GASB 96 Subscription Liabilities	21,561,250
Less Accumulated Depreciation	(86,538,713)	Community Reinvestment	90,646,728
Capital Assets, Net of Depreciation	**102,691,674**	Capital Lease Payable	241,474
		Postemployment Health Care Plan	17,256,358
Other Assets		Net Pension Liabilities	5,840,992
Restricted Deposits	300,000	**Total Other Liabilities**	**135,546,802**
Board Designated Reserves	1,584,624,044		
Statutory Designated Reserves	132,296,848	**TOTAL LIABILITIES**	**1,488,735,501**
Total Other Assets	**1,717,220,892**		
TOTAL ASSETS	**4,279,447,618**	**Deferred Inflows**	**4,309,519**
Deferred Outflows	**28,626,072**	**Net Position**	
		Required TNE	129,265,189
		Funds in Excess of TNE	2,685,763,481
		TOTAL NET POSITION	**2,815,028,671**
TOTAL ASSETS & DEFERRED OUTFLOWS	**4,308,073,690**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**4,308,073,690**

CalOptima Health

Board Designated Reserve and TNE Analysis: As of July 2025

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	792,394,311				
MetLife Tier One	792,229,732				
Board Designated Reserves	1,584,624,044	1,052,137,734	1,683,420,374	532,486,310	(98,796,330)
Current Reserve Level (X months of average monthly revenue) [1]	*3.77*	*2.50*	*4.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	66,272,379				
MetLife Tier Two	66,024,469				
Statutory Designated Reserves	132,296,848	129,265,189	142,191,708	3,031,659	(9,894,860)
Current Reserve Level (X min. TNE) [1]	*1.02*	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

CalOptima Health

Spending Plan: As of July 2025

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 7/31/2025	**$2,815.0**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,584.6**			**56.3%**
	Statutory Designated Reserve[1]	**$132.3**			**4.7%**
	Capital Assets, net of Depreciation	**$102.7**			**3.6%**
Resources Allocated[3]	Homeless Health Initiative[2]	$20.7	$65.9	$45.2	0.7%
	Housing and Homelessness Incentive Program[2]	25.8	87.4	61.5	0.9%
	Intergovernmental Transfers (IGT)[3]	45.0	52.1	7.0	1.6%
	Digital Transformation and Workplace Modernization	28.4	100.0	71.6	1.0%
	CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
	CalFresh and Redetermination Outreach Strategy	1.7	6.0	4.3	0.1%
	Coalition of Orange County Community Health Centers Grant	25.7	50.0	24.3	0.9%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	General Awareness Campaign	0.3	4.7	4.4	0.0%
	Member Health Needs Assessment	0.6	1.3	0.7	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	119.0	153.5	34.5	4.2%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.4%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program Grant	3.0	5.0	2.0	0.1%
	Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program Grant	1.5	2.7	1.2	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	44.5	50.0	5.5	1.6%
	Distribution Event - Naloxone Grant	2.2	15.0	12.8	0.1%
	Garden Grove Bldg. Improvement	9.8	10.5	0.7	0.3%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.3%
	Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
	Outreach Strategy for newly eligible Adult Expansion members	3.2	7.6	4.4	0.1%
	Quality Initiatives from unearned Pay for Value Program	18.8	23.3	4.5	0.7%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.2	1.2	1.0	0.0%
	Medi-Cal Provider Rate Increases	298.2	526.2	228.0	10.6%
	Homeless Prevention and Stabilization Pilot Program	0.2	0.3	0.1	0.0%
	OneCare Member Engagement and Education	0.3	0.3	0.0	0.0%
	Subtotal:	**$700.2**	**$1,236.7**	**$536.5**	**24.9%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$295.2**			**10.5%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 169 days of CalOptima Health's current operations.

[2] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.

[3] On June 5, 2025, the Board of Directors approved the close out of Board-approved initiatives and transfer of remaining funds back to unallocated reserves.

CalOptima Health

Homeless Health Initiative and Allocated Funds: As of July 2025

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
HHI - IGT'S	64,131,301	64,131,301	45,175,789	18,955,511	-
HHI - Existing Reserves	1,800,000	1,800,000	-	1,800,000	-
HHIP	40,100,000	40,100,000	-	40,100,000	-
Total	**106,031,301**	**106,031,301**	**45,175,789**	**60,855,511**	**-**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-	IGT's
Recuperative Care	6,194,190	6,194,190	-	IGT's
Medical Respite	250,000	250,000	-	IGT's
Day Habilitation (County for HomeKey)	2,500,000	-	2,500,000	IGT's
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-	IGT's
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-	IGT's
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522	IGT's
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	925,540	37,721	IGT's
FQHC (Community Health Center) Expansion	21,902	21,902	-	IGT's
HCAP and CalOptima Health Days	9,888,914	4,335,100	5,553,813	IGT's
Vaccination Intervention and Member Incentive Strategy[1]	54,649	54,649	-	IGT's
Street Medicine[2]	14,376,652	7,618,190	6,758,462	IGT's & Existing Reserves
Outreach and Engagement	7,000,000	1,138,008	5,861,992	IGT's
Housing and Homelessness Incentive Program (HHIP)[3]	40,100,000	-	40,100,000	IGT's & Existing Reserves
Subtotal of Approved Initiatives	**106,031,301**	**45,175,789**	**60,855,511**	
Transfer of funds to HHIP[3]	(40,100,000)	-	(40,100,000)	
Program Total	**65,931,301**	**45,175,789**	**20,755,511**	

[1]On June 5, 2025 the Board of Directors approved the close out of the Vaccination Intervention and Member Incentive Strategy program and transfer of the remaining funds of $68,699 to unallocated reserves for new initiatives.

[2]On March 19, 2025, CalOptima Health's Board of Directors approved $4.3 million from existing reserves to fund a new Street Medicine Program (Santa Ana). On March 7, 2024, CalOptima Health's Board of Directors approved $5.0 million to expand the Street Medicine Program. $3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and $1.8 million from existing reserves to fund 2-year agreements with Healthcare in Action (Anaheim) and Celebrating Life Community Health Center (Costa Mesa).

[3]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP.

CalOptima Health

Housing and Homelessness Incentive Program: As of July 2025

Summary by Funding Source:	Total Funds[1]	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	54,930,994	31,576,010	23,354,985	$18,000,195
Existing Reserves & HHI Transfer	87,384,530	87,384,530	61,543,126	25,841,404	-
Total	**160,315,719**	**142,315,524**	**93,119,136**	**49,196,389**	**18,000,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	862,350	537,650	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,696,311	925,000	HHI & DHCS
Infrastructure Projects	5,832,314	5,580,354	251,960	HHI
Capital Projects	108,247,369	73,195,575	35,051,794	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	6,929,155	3,255,375	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	**$133,185,524[1]**	**$93,119,136**	**$40,066,389**	

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments.

CalOptima Health

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UNAUDITED FINANCIAL STATEMENTS

July 31, 2025

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CalOptima Health - Consolidated
Financial Highlights
For the One Month Ending July 31, 2025

	July 2025			
	Actual	**Budget**	**$ Variance**	**% Variance**
Member Months	904,278	906,467	(2,189)	(0.2%)
Revenues	396,458,146	399,374,664	(2,916,518)	(0.7%)
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Other Income/Expense	(140,313)	(138,610)	(1,703)	(1.2%)
Total Non-Operating Income (Loss)	**5,228,202**	**8,194,730**	**(2,966,528)**	**(36.2%)**
Change in Net Assets	**14,444,969**	**11,098,652**	**3,346,317**	**30.2%**
Medical Loss Ratio	*92.5%*	*92.9%*	*(0.4%)*	
Administrative Loss Ratio	*5.2%*	*6.4%*	*1.2%*	
Operating Margin Ratio	*2.3%*	*0.7%*	*1.6%*	
Total Operating	*100.0%*	*100.0%*		
**Adjusted MLR*	*88.1%*	*88.5%*	*(0.4%)*	
**Adjusted ALR*	*5.2%*	*6.4%*	*1.2%*	

*Adjusted MLR /ALR excludes estimated Board-approved Provider Rate increases and Directed Payments, but includes costs associated with CalOptima Health's Digital Transformation Strategy (DTS) budget.

CalOptima Health

Highlights – Consolidated, for the One Month Ending July 31, 2025

MONTH TO DATE RESULTS:

- Change in Net Assets is $14.4 million, favorable to budget $3.3 million
- Operating surplus is $9.2 million, with a surplus in non-operating income of $5.2 million

Change in Net Assets by Line of Business (LOB) ($ millions):

July 2025			
Operating Income (Loss)	**Actual**	**Budget**	**Variance**
Medi-Cal	11.6	5.4	6.2
OneCare	(2.6)	(1.9)	(0.7)
PACE	0.4	0.2	0.2
MSSP	(0.1)	(0.1)	0.0
Covered CA	(0.1)	(0.7)	0.6
Total Operating Income (Loss)	**9.2**	**2.9**	**6.3**
Non-Operating Income (Loss)			
Net Investment Income/Expense	7.9	8.3	(0.4)
Other Income/Expense	(2.7)	(0.1)	(2.6)
Total Non-Operating Income/(Loss)	**5.2**	**8.2**	**(3.0)**
TOTAL	**14.4**	**11.1**	**3.3**

CalOptima Health - Consolidated
Full Time Equivalent (FTE) Data
For the One Month Ending July 31, 2025

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1,331	1,405	74
OneCare	165	180	15
PACE	112	119	7
CCA	2	7	5
MSSP	22	24	2
Total	1,632	1,735	103

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	665	632	(33)
OneCare	109	98	(11)
PACE	5	4	(1)
CCA	0	0	0
MSSP	25	23	(2)
Consolidated	554	523	(31)

Open FTE			
	Total	Medical	Admin
Medi-Cal	90	32	58
OneCare	16	4	12
PACE	6	6	0
CCA	18	1	17
MSSP	0	0	0
Total	130	43	87

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending July 31, 2025

MEMBER MONTHS		904,278		906,467		(2,189)
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$355,958,648	$401.86	$357,007,798	$401.93	($1,049,150)	($0.07)
OneCare	35,505,096	1,975.69	37,361,441	2,111.41	(1,856,345)	(135.72)
PACE	4,742,424	8,981.86	4,756,371	8,991.25	(13,947)	(9.39)
MSSP	251,978	455.66	249,054	446.33	2,924	9.33
Total Operating Revenue	396,458,146	438.43	399,374,664	440.58	(2,916,518)	(2.15)
MEDICAL EXPENSES						
Medi-Cal	327,103,811	369.28	330,380,686	371.95	3,276,875	2.67
OneCare	35,362,768	1,967.77	36,008,016	2,034.93	645,248	67.16
PACE	4,009,510	7,593.77	4,210,122	7,958.64	200,612	364.87
MSSP	237,413	429.32	227,092	406.97	(10,321)	(22.35)
Covered CA		-	44,984	80.62	44,984	80.62
Total Medical Expenses	366,713,502	405.53	370,870,900	409.14	4,157,398	3.61
GROSS MARGIN	29,744,644	32.90	28,503,764	31.44	1,240,880	1.46
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	13,297,522	14.71	14,418,732	15.91	1,121,210	1.20
Professional Fees	922,578	1.02	1,893,603	2.09	971,024	1.07
Purchased Services	1,971,222	2.18	2,713,817	2.99	742,595	0.81
Printing & Postage	524,992	0.58	627,975	0.69	102,983	0.11
Depreciation & Amortization	804,964	0.89	949,334	1.05	144,370	0.16
Other Expenses	2,567,757	2.84	4,514,513	4.98	1,946,757	2.14
Indirect Cost Allocation, Occupancy	438,842	0.49	481,868	0.53	43,026	0.04
Total Administrative Expenses	20,527,877	22.70	25,599,842	28.24	5,071,965	5.54
NET INCOME (LOSS) FROM OPERATIONS	9,216,767	10.19	2,903,922	3.20	6,312,845	6.99
INVESTMENT INCOME						
Interest Income	14,321,440	15.84	8,333,340	9.19	5,988,100	6.65
Realized Gain/(Loss) on Investments	844,794	0.93	-	-	844,794	0.93
Unrealized Gain/(Loss) on Investments	(7,249,102)	(8.02)	-	-	(7,249,102)	(8.02)
Total Investment Income	7,917,132	8.76	8,333,340	9.19	(416,208)	(0.43)
COMMUNITY REINVESTMENT	(2,548,617)	(2.82)	-	-	(2,548,617)	(2.82)
OTHER INCOME/EXPENSE	(140,313)	(0.16)	(138,610)	(0.15)	(1,703)	(0.01)
CHANGE IN NET ASSETS	**14,444,969**	**15.97**	**11,098,652**	**12.24**	**3,346,317**	**3.73**
MEDICAL LOSS RATIO	**92.5%**		**92.9%**		**(0.4%)**	
ADMINISTRATIVE LOSS RATIO	**5.2%**		**6.4%**		**1.2%**	

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CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending July 31, 2025

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	885,779	17,971	528	553	-	904,278
REVENUES						
Capitation Revenue	$ 355,958,648	$ 35,505,096	$ 4,742,424	$ 251,978	$ -	$ 396,458,146
Total Operating Revenue	**355,958,648**	**35,505,096**	**4,742,424**	**251,978**	**-**	**396,458,146**
MEDICAL EXPENSES						
Provider Capitation	113,767,195	14,756,132				128,523,327
Professional, Facility & Ancillary Claims	143,443,310	7,105,399	1,988,286			152,536,996
MLTSS	48,971,239		9,367	42,072		49,022,678
Prescription Drugs		10,815,996	569,433			11,385,430
Case Mgmt & Other Medical	20,922,067	2,685,241	1,442,423	195,341		25,245,072
Total Medical Expenses	**327,103,811**	**35,362,768**	**4,009,510**	**237,413**	**-**	**366,713,502**
Medical Loss Ratio	*91.9%*	*99.6%*	*84.5%*	*94.2%*	*0.0%*	*92.5%*
GROSS MARGIN	**28,854,837**	**142,327**	**732,914**	**14,565**	**-**	**29,744,644**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	11,936,021	1,015,914	186,943	105,547	53,097	13,297,522
Non-Salary Operating Expenses	2,854,078	420,599	92,343	1,457	50,315	3,418,792
Depreciation & Amortization	804,078		886			804,964
Other Operating Expenses	2,472,439	82,027	7,893	5,399		2,567,757
Indirect Cost Allocation, Occupancy	(767,028)	1,181,620	16,670	7,580		438,842
Total Administrative Expenses	**17,299,587**	**2,700,160**	**304,735**	**119,982**	**103,413**	**20,527,877**
Administrative Loss Ratio	*4.9%*	*7.6%*	*6.4%*	*47.6%*	*0.0%*	*5.2%*
Operating Income/(Loss)	**11,555,251**	**(2,557,832)**	**428,179**	**(105,418)**	**(103,413)**	**9,216,767**
Investments and Other Non-Operating	(2,547,016)					5,228,202
CHANGE IN NET ASSETS	**$ 9,008,235**	**$ (2,557,832)**	**$ 428,179**	**$ (105,418)**	**$ (103,413)**	**$ 14,444,969**
BUDGETED CHANGE IN NET ASSETS	5,389,487	(1,859,310)	219,283	(123,362)	(722,176)	11,098,653
Variance to Budget - Fav/(Unfav)	$ 3,618,748	$ (698,522)	$ 208,896	$ 17,944	$ 618,763	$ 3,346,316

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CalOptima Health - Consolidated
Enrollment Summary
For the One Month Ending July 31, 2025

	July 2025			
Enrollment (by Aid Category)	**Actual**	**Budget**	**$ Variance**	**%Variance**
SPD	152,402	147,168	5,234	3.6%
TANF Child	257,426	260,147	(2,721)	(1.0%)
TANF Adult	128,566	130,415	(1,849)	(1.4%)
LTC	2,600	2,513	87	3.5%
MCE	335,621	338,880	(3,259)	(1.0%)
WCM	9,164	9,120	44	0.5%
Medi-Cal Total	**885,779**	**888,243**	**(2,464)**	**(0.3%)**
OneCare	**17,971**	**17,695**	**276**	**1.6%**
PACE	**528**	**529**	**(1)**	**(0.2%)**
MSSP*	**553**	**558**	**(5)**	**(0.9%)**
CalOptima Health Total	**904,278**	**906,467**	**(2,189)**	**(0.2%)**
Enrollment (by Network)				
HMO	345,952	353,658	(7,706)	(2.2%)
PHC	166,441	166,067	374	0.2%
Shared Risk Group	67,943	67,867	76	0.1%
Fee for Service	305,443	300,651	4,792	1.6%
Medi-Cal Total	**885,779**	**888,243**	**(2,464)**	**(0.3%)**
OneCare	**17,971**	**17,695**	**276**	**1.6%**
PACE	**528**	**529**	**(1)**	**(0.2%)**
MSSP*	**553**	**558**	**(5)**	**(0.9%)**
CalOptima Health Total	**904,278**	**906,467**	**(2,189)**	**(0.2%)**

* Total membership does not include MSSP

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CalOptima Health
Enrollment Trend by Network
Fiscal Year 2026

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD Actual	YTD Budget	Variance
HMOs															
SPD	20,739												20,739	20,074	665
TANF Child	73,203												73,203	76,706	(3,503)
TANF Adult	67,587												67,587	68,666	(1,079)
LTC	3												3	1	2
MCE	182,912												182,912	186,779	(3,867)
WCM	1,508												1,508	1,431	77
Total	345,952												345,952	353,657	**(7,705)**
PHCs															
SPD	4,775												4,775	4,606	169
TANF Child	129,804												129,804	129,353	451
TANF Adult	3,936												3,936	4,028	(92)
LTC													0		0
MCE	21,807												21,807	21,981	(174)
WCM	6,119												6,119	6,098	21
Total	166,441												166,441	166,066	**375**
Shared Risk Groups															
SPD	3,418												3,418	3,194	224
TANF Child	18,444												18,444	18,011	433
TANF Adult	11,382												11,382	11,440	(58)
LTC													0		0
MCE	34,473												34,473	34,845	(372)
WCM	226												226	377	(151)
Total	**67,943**												**67,943**	**67,867**	**76**
Fee for Service (Dual)															
SPD	107,827												107,827	103,141	4,686
TANF Child													0		0
TANF Adult	876												876	1,119	(243)
LTC	2,311												2,311	2,228	83
MCE	3,187												3,187	5,248	(2,061)
WCM	15												15	15	0
Total	**114,216**												**114,216**	**111,751**	**2,465**
Fee for Service (Non-Dual - Total)															
SPD	15,643												15,643	16,151	(508)
TANF Child	35,975												35,975	36,077	(102)
TANF Adult	44,785												44,785	45,162	(377)
LTC	286												286	284	2
MCE	93,242												93,242	90,027	3,215
WCM	1,296												1,296	1,199	97
Total	**191,227**												**191,227**	**188,900**	**2,327**
Grand Totals															
SPD	152,402												152,402	147,168	5,234
TANF Child	257,426												257,426	260,147	(2,721)
TANF Adult	128,566												128,566	130,415	(1,849)
LTC	2,600												2,600	2,513	87
MCE	335,621												335,621	338,880	(3,259)
WCM	9,164												9,164	9,120	44
Total MediCal MM	**885,779**												**885,779**	**888,243**	**(2,464)**
OneCare	**17,971**												**17,971**	**17,695**	**276**
PACE	**528**												**528**	**529**	**(1)**
MSSP*	**553**												**553**	**558**	**(5)**
Grand Total	**904,278**												**904,278**	**906,467**	**(2,189)**

* Total membership does not include MSSP

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ENROLLMENT– JULY MONTH:

Overall, July enrollment was 904,278

- Unfavorable to budget 2,189 or 0.2%
- Increased 65 or 0.0% from Prior Month (PM) (June 2025)
- Decreased 6,650 or 0.7% from Prior Year (PY) (July 2024)

Medi-Cal enrollment was 885,779

- Unfavorable to budget 2,464 or 0.3%
- Temporary Assistance for Needy Families (TANF) unfavorable to budget 4,570
- Medi-Cal Expansion (MCE) unfavorable to budget 3,259
- Seniors and Persons with Disabilities (SPD) favorable to budget 5,234
- Long-Term Care (LTC) favorable to budget 87
- Whole Child Model (WCM) favorable to budget 44
- Decreased 255 or 0.0% from PM

OneCare enrollment was 17,971

- Favorable to budget 276 or 1.6%
- Increased 307 or 1.7% from PM

PACE enrollment was 528

- Unfavorable to budget 1 or 0.2%
- Increased 13 or 2.5% from PM

MSSP enrollment was 553

- Unfavorable to budget 5 or 0.9%
- Increased 14 or 2.6% from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the One Month Ending July 31, 2025

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
885,779	**888,243**	**(2,464)**	**(0.3%)**	**Member Months**	**885,779**	**888,243**	**(2,464)**	**(0.3%)**
				Revenues				
355,958,648	357,007,798	(1,049,150)	(0.3%)	Medi-Cal Capitation Revenue	355,958,648	357,007,798	(1,049,150)	(0.3%)
355,958,648	**357,007,798**	**(1,049,150)**	**(0.3%)**	**Total Operating Revenue**	**355,958,648**	**357,007,798**	**(1,049,150)**	**(0.3%)**
				Medical Expenses				
113,767,195	114,700,882	933,687	0.8%	Provider Capitation	113,767,195	114,700,882	933,687	0.8%
67,192,689	67,599,750	407,061	0.6%	Facilities Claims	67,192,689	67,599,750	407,061	0.6%
76,250,622	75,204,754	(1,045,868)	(1.4%)	Professional Claims	76,250,622	75,204,754	(1,045,868)	(1.4%)
48,971,239	50,087,522	1,116,283	2.2%	MLTSS	48,971,239	50,087,522	1,116,283	2.2%
10,565,414	9,608,057	(957,357)	(10.0%)	Incentive Payments	10,565,414	9,608,057	(957,357)	(10.0%)
8,556,607	11,316,793	2,760,186	24.4%	Medical Management	8,556,607	11,316,793	2,760,186	24.4%
1,800,046	1,862,928	62,882	3.4%	Other Medical Expenses	1,800,046	1,862,928	62,882	3.4%
327,103,811	**330,380,686**	**3,276,875**	**1.0%**	**Total Medical Expenses**	**327,103,811**	**330,380,686**	**3,276,875**	**1.0%**
28,854,837	**26,627,112**	**2,227,725**	**8.4%**	**Gross Margin**	**28,854,837**	**26,627,112**	**2,227,725**	**8.4%**
				Administrative Expenses				
11,936,021	12,707,077	771,057	6.1%	Salaries, Wages & Employee Benefits	11,936,021	12,707,077	771,057	6.1%
754,376	1,342,321	587,945	43.8%	Professional Fees	754,376	1,342,321	587,945	43.8%
1,613,662	2,171,468	557,806	25.7%	Purchased Services	1,613,662	2,171,468	557,806	25.7%
486,040	485,060	(980)	(0.2%)	Printing & Postage	486,040	485,060	(980)	(0.2%)
804,078	947,712	143,634	15.2%	Depreciation & Amortization	804,078	947,712	143,634	15.2%
2,472,439	4,325,363	1,852,925	42.8%	Other Operating Expenses	2,472,439	4,325,363	1,852,925	42.8%
(767,028)	(741,376)	25,652	3.5%	Indirect Cost Allocation, Occupancy	(767,028)	(741,376)	25,652	3.5%
17,299,587	**21,237,625**	**3,938,038**	**18.5%**	**Total Administrative Expenses**	**17,299,587**	**21,237,625**	**3,938,038**	**18.5%**
				Non-Operating Income (Loss)				
(2,548,617)	-	(2,548,617)	(100.0%)	Community Reinvestment	(2,548,617)	-	(2,548,617)	(100.0%)
1,601	-	1,601	100.0%	Other Income/Expense	1,601	-	1,601	100.0%
(2,547,016)	**-**	**(2,547,016)**	**(100.0%)**	**Total Non-Operating Income (Loss)**	**(2,547,016)**	**-**	**(2,547,016)**	**(100.0%)**
9,008,235	**5,389,487**	**3,618,748**	**67.1%**	**Change in Net Assets**	**9,008,235**	**5,389,487**	**3,618,748**	**67.1%**
91.9%	***92.5%***	***(0.6%)***		***Medical Loss Ratio***	***91.9%***	***92.5%***	***(0.6%)***	
4.9%	***5.9%***	***1.1%***		***Admin Loss Ratio***	***4.9%***	***5.9%***	***1.1%***	

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MEDI-CAL INCOME STATEMENT– JULY MONTH:

REVENUES are $356.0 million, unfavorable to budget $1.0 million:

- Unfavorable volume variance of $1.0 million

MEDICAL EXPENSES are $327.1 million, favorable to budget $3.3 million:

- Favorable volume variance of $0.9 million
- Favorable price related variance of $2.4 million:
  - Medical Management expense favorable variance of $2.7 million due to timing of program activities
  - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $1.0 million
  - Provider Capitation expense favorable variance of $0.6 million
  - Facilities Claims expense favorable variance of $0.2 million
  - Other Medical Expenses favorable variance of $0.1 million
  - Offset by:
    - Professional Claims expense unfavorable variance of $1.3 million
    - Incentive Payments expense unfavorable variance of $1.0 million

ADMINISTRATIVE EXPENSES are $17.3 million, favorable to budget $3.9 million:

- Non-Salary expense favorable to budget $3.2 million
- Salaries, Wages & Employee Benefits expense favorable to budget $0.8 million

CHANGE IN NET ASSETS is $9.0 million, favorable to budget $3.6 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the One Month Ending July 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
17,971	**17,695**	**276**	**1.6%**	**Member Months**	**17,971**	**17,695**	**276**	**1.6%**
				Revenues				
25,543,824	27,812,759	(2,268,935)	(8.2%)	Medicare Part C Revenue	25,543,824	27,812,759	(2,268,935)	(8.2%)
9,961,271	9,548,682	412,589	4.3%	Medicare Part D Revenue	9,961,271	9,548,682	412,589	4.3%
35,505,096	**37,361,441**	**(1,856,345)**	**(5.0%)**	**Total Operating Revenue**	**35,505,096**	**37,361,441**	**(1,856,345)**	**(5.0%)**
				Medical Expenses				
14,756,132	16,200,206	1,444,074	8.9%	Provider Capitation	14,756,132	16,200,206	1,444,074	8.9%
4,666,266	5,069,969	403,703	8.0%	Facilities Claims	4,666,266	5,069,969	403,703	8.0%
2,439,133	1,999,620	(439,513)	(22.0%)	Professional Claims	2,439,133	1,999,620	(439,513)	(22.0%)
10,815,996	10,454,478	(361,518)	(3.5%)	Prescription Drugs	10,815,996	10,454,478	(361,518)	(3.5%)
868,277	627,202	(241,075)	(38.4%)	Incentive Payments	868,277	627,202	(241,075)	(38.4%)
1,054,374	1,544,751	490,377	31.7%	Medical Management	1,054,374	1,544,751	490,377	31.7%
762,590	111,790	(650,800)	(582.2%)	Other Medical Expenses	762,590	111,790	(650,800)	(582.2%)
35,362,768	**36,008,016**	**645,248**	**1.8%**	**Total Medical Expenses**	**35,362,768**	**36,008,016**	**645,248**	**1.8%**
142,327	**1,353,425**	**(1,211,098)**	**(89.5%)**	**Gross Margin**	**142,327**	**1,353,425**	**(1,211,098)**	**(89.5%)**
				Administrative Expenses				
1,015,914	1,228,969	213,055	17.3%	Salaries, Wages & Employee Benefits	1,015,914	1,228,969	213,055	17.3%
111,639	117,716	6,077	5.2%	Professional Fees	111,639	117,716	6,077	5.2%
275,235	420,687	145,452	34.6%	Purchased Services	275,235	420,687	145,452	34.6%
33,725	121,107	87,382	72.2%	Printing & Postage	33,725	121,107	87,382	72.2%
82,027	126,089	44,062	34.9%	Other Operating Expenses	82,027	126,089	44,062	34.9%
1,181,620	1,198,167	16,547	1.4%	Indirect Cost Allocation, Occupancy	1,181,620	1,198,167	16,547	1.4%
2,700,160	**3,212,735**	**512,575**	**16.0%**	**Total Administrative Expenses**	**2,700,160**	**3,212,735**	**512,575**	**16.0%**
(2,557,832)	**(1,859,310)**	**(698,522)**	**(37.6%)**	**Change in Net Assets**	**(2,557,832)**	**(1,859,310)**	**(698,522)**	**(37.6%)**
99.6%	***96.4%***	***3.2%***		***Medical Loss Ratio***	***99.6%***	***96.4%***	***3.2%***	
7.6%	***8.6%***	***1.0%***		***Admin Loss Ratio***	***7.6%***	***8.6%***	***1.0%***	

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ONECARE INCOME STATEMENT – JULY MONTH:

REVENUES are $35.5 million, unfavorable to budget $1.9 million:

- Favorable volume related variance of $0.6 million
- Unfavorable price related variance of $2.4 million driven by lower than anticipated Risk Adjustment Factor (RAF)

MEDICAL EXPENSES are $35.4 million, favorable to budget $0.6 million:

- Unfavorable volume related variance of $0.6 million
- Favorable price related variance of $1.2 million

ADMINISTRATIVE EXPENSES are $2.7 million, favorable to budget $0.5 million

- Non-Salary expense favorable to budget $0.3 million
- Salaries, Wages & Employee Benefits expense favorable to budget $0.2 million

CHANGE IN NET ASSETS is ($2.6) million, unfavorable to budget $0.7 million

CalOptima Health
PACE
Statement of Revenues and Expenses
For the One Month Ending July 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
528	**529**	**(1)**	**(0.2%)**	**Member Months**	**528**	**529**	**(1)**	**(0.2%)**
				Revenues				
3,626,594	3,614,124	12,470	0.3%	Medi-Cal Capitation Revenue	3,626,594	3,614,124	12,470	0.3%
746,686	820,718	(74,032)	(9.0%)	Medicare Part C Revenue	746,686	820,718	(74,032)	(9.0%)
369,143	321,529	47,614	14.8%	Medicare Part D Revenue	369,143	321,529	47,614	14.8%
4,742,424	**4,756,371**	**(13,947)**	**(0.3%)**	**Total Operating Revenue**	**4,742,424**	**4,756,371**	**(13,947)**	**(0.3%)**
				Medical Expenses				
1,442,423	1,626,891	184,468	11.3%	Medical Management	1,442,423	1,626,891	184,468	11.3%
867,932	810,209	(57,723)	(7.1%)	Facilities Claims	867,932	810,209	(57,723)	(7.1%)
806,641	764,466	(42,175)	(5.5%)	Professional Claims	806,641	764,466	(42,175)	(5.5%)
569,433	702,676	133,243	19.0%	Prescription Drugs	569,433	702,676	133,243	19.0%
9,367	34,419	25,052	72.8%	MLTSS	9,367	34,419	25,052	72.8%
313,713	271,461	(42,252)	(15.6%)	Patient Transportation	313,713	271,461	(42,252)	(15.6%)
4,009,510	**4,210,122**	**200,612**	**4.8%**	**Total Medical Expenses**	**4,009,510**	**4,210,122**	**200,612**	**4.8%**
732,914	**546,249**	**186,665**	**34.2%**	**Gross Margin**	**732,914**	**546,249**	**186,665**	**34.2%**
				Administrative Expenses				
186,943	191,348	4,405	2.3%	Salaries, Wages & Employee Benefits	186,943	191,348	4,405	2.3%
4,792	13,733	8,941	65.1%	Professional Fees	4,792	13,733	8,941	65.1%
82,325	69,662	(12,663)	(18.2%)	Purchased Services	82,325	69,662	(12,663)	(18.2%)
5,226	21,787	16,561	76.0%	Printing & Postage	5,226	21,787	16,561	76.0%
886	1,622	736	45.4%	Depreciation & Amortization	886	1,622	736	45.4%
7,893	11,320	3,427	30.3%	Other Operating Expenses	7,893	11,320	3,427	30.3%
16,670	17,494	824	4.7%	Indirect Cost Allocation, Occupancy	16,670	17,494	824	4.7%
304,735	**326,966**	**22,231**	**6.8%**	**Total Administrative Expenses**	**304,735**	**326,966**	**22,231**	**6.8%**
428,179	**219,283**	**208,896**	**95.3%**	**Change in Net Assets**	**428,179**	**219,283**	**208,896**	**95.3%**
84.5%	***88.5%***	***(4.0%)***		***Medical Loss Ratio***	***84.5%***	***88.5%***	***(4.0%)***	
6.4%	***6.9%***	***0.4%***		***Admin Loss Ratio***	***6.4%***	***6.9%***	***0.4%***	

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CalOptima Health
Multipurpose Senior Services Program (MSSP)
Statement of Revenues and Expenses
For the One Month Ending July 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
553	**558**	**(5)**	**(0.9%)**	**Member Months**	**553**	**558**	**(5)**	**(0.9%)**
				Revenues				
251,978	249,054	2,924	1.2%	Revenue	251,978	249,054	2,924	1.2%
251,978	**249,054**	**2,924**	**1.2%**	**Total Operating Revenue**	**251,978**	**249,054**	**2,924**	**1.2%**
				Medical Expenses				
195,341	194,133	(1,208)	(0.6%)	Medical Management	195,341	194,133	(1,208)	(0.6%)
42,072	32,959	(9,113)	(27.7%)	Waiver Services	42,072	32,959	(9,113)	(27.7%)
195,341	194,133	(1,208)	(0.6%)	Total Medical Management	195,341	194,133	(1,208)	(0.6%)
42,072	32,959	(9,113)	(27.7%)	Total Waiver Services	42,072	32,959	(9,113)	(27.7%)
237,413	**227,092**	**(10,321)**	**(4.5%)**	**Total Program Expenses**	**237,413**	**227,092**	**(10,321)**	**(4.5%)**
14,565	**21,962**	**(7,397)**	**(33.7%)**	**Gross Margin**	**14,565**	**21,962**	**(7,397)**	**(33.7%)**
				Administrative Expenses				
105,547	127,721	22,174	17.4%	Salaries, Wages & Employee Benefits	105,547	127,721	22,174	17.4%
1,457	1,500	43	2.9%	Professional Fees	1,457	1,500	43	2.9%
5,399	8,520	3,121	36.6%	Other Operating Expenses	5,399	8,520	3,121	36.6%
7,580	7,583	3	0.0%	Indirect Cost Allocation, Occupancy	7,580	7,583	3	0.0%
119,982	**145,324**	**25,342**	**17.4%**	**Total Administrative Expenses**	**119,982**	**145,324**	**25,342**	**17.4%**
(105,418)	**(123,362)**	**17,944**	**14.5%**	**Change in Net Assets**	**(105,418)**	**(123,362)**	**17,944**	**14.5%**
94.2%	***91.2%***	***3.0%***		***Medical Loss Ratio***	***94.2%***	***91.2%***	***3.0%***	
47.6%	***58.4%***	***10.7%***		***Admin Loss Ratio***	***47.6%***	***58.4%***	***10.7%***	

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CalOptima Health
Covered CA
Statement of Revenues and Expenses
For the One Month Ending July 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
-	**-**	**-**	**0.0%**	**Member Months**	**-**	**-**	**-**	**0.0%**
				Revenues				
-	-	-	0.0%	Medi-Cal Capitation Revenue	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Medical Expenses				
-	44,984	44,984	100.0%	Medical Management	-	44,984	44,984	100.0%
-	**44,984**	**44,984**	**100.0%**	**Total Medical Expenses**	**-**	**44,984**	**44,984**	**100.0%**
-	**(44,984)**	**44,984**	**(100.0%)**	**Gross Margin**	**-**	**(44,984)**	**44,984**	**(100.0%)**
				Administrative Expenses				
53,097	163,617	110,520	67.5%	Salaries, Wages & Employee Benefits	53,097	163,617	110,520	67.5%
50,315	418,333	368,018	88.0%	Professional Fees	50,315	418,333	368,018	88.0%
-	52,000	52,000	100.0%	Purchased Services	-	52,000	52,000	100.0%
-	21	21	100.0%	Printing & Postage	-	21	21	100.0%
-	43,221	43,221	100.0%	Other Operating Expenses	-	43,221	43,221	100.0%
103,413	**677,192**	**573,779**	**84.7%**	**Total Administrative Expenses**	**103,413**	**677,192**	**573,779**	**84.7%**
(103,413)	**(722,176)**	**618,763**	**85.7%**	**Change in Net Assets**	**(103,413)**	**(722,176)**	**618,763**	**85.7%**
0.0%	***0.0%***	***0.0%***		***Medical Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	

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CalOptima Health
Building - 505 City Parkway
Statement of Revenues and Expenses
For the One Month Ending July 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
63,911	29,708	(34,203)	(115.1%)	Purchased Services	63,911	29,708	(34,203)	(115.1%)
185,353	191,643	6,290	3.3%	Depreciation & Amortization	185,353	191,643	6,290	3.3%
23,371	25,124	1,753	7.0%	Insurance Expense	23,371	25,124	1,753	7.0%
207,444	219,809	12,365	5.6%	Repair & Maintenance	207,444	219,809	12,365	5.6%
57,733	59,093	1,360	2.3%	Other Operating Expenses	57,733	59,093	1,360	2.3%
(537,812)	(525,376)	12,436	2.4%	Indirect Cost Allocation, Occupancy	(537,812)	(525,376)	12,436	2.4%
-	**1**	**1**	**100.0%**	**Total Administrative Expenses**	**-**	**1**	**1**	**100.0%**
-	**(1)**	**1**	**(100.0%)**	**Change in Net Assets**	**-**	**(1)**	**1**	**(100.0%)**

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CalOptima Health
Building - 500 City Parkway
Statement of Revenues and Expenses
For the One Month Ending July 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
127,491	118,206	9,285	7.9%	Rental Income	127,491	118,206	9,285	7.9%
127,491	**118,206**	**9,285**	**7.9%**	**Total Operating Revenue**	**127,491**	**118,206**	**9,285**	**7.9%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
41,693	19,131	(22,562)	(117.9%)	Purchased Services	41,693	19,131	(22,562)	(117.9%)
58,789	75,663	16,874	22.3%	Depreciation & Amortization	58,789	75,663	16,874	22.3%
8,600	9,245	645	7.0%	Insurance Expense	8,600	9,245	645	7.0%
93,575	104,657	11,082	10.6%	Repair & Maintenance	93,575	104,657	11,082	10.6%
45,749	31,298	(14,451)	(46.2%)	Other Operating Expenses	45,749	31,298	(14,451)	(46.2%)
(26,307)	(25,416)	891	3.5%	Indirect Cost Allocation, Occupancy	(26,307)	(25,416)	891	3.5%
222,099	**214,578**	**(7,521)**	**(3.5%)**	**Total Administrative Expenses**	**222,099**	**214,578**	**(7,521)**	**(3.5%)**
(94,608)	**(96,372)**	**1,764**	**1.8%**	**Change in Net Assets**	**(94,608)**	**(96,372)**	**1,764**	**1.8%**

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CalOptima Health
Building - 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the One Month Ending July 31, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
29,860	3,333	(26,527)	(795.9%)	Purchased Services	29,860	3,333	(26,527)	(795.9%)
9,397	9,651	254	2.6%	Depreciation & Amortization	9,397	9,651	254	2.6%
4,751	-	(4,751)	(100.0%)	Insurance Expense	4,751	-	(4,751)	(100.0%)
2,298	28,533	26,235	91.9%	Repair & Maintenance	2,298	28,533	26,235	91.9%
1,000	720	(280)	(38.9%)	Other Operating Expenses	1,000	720	(280)	(38.9%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
47,306	**42,237**	**(5,069)**	**(12.0%)**	**Total Administrative Expenses**	**47,306**	**42,237**	**(5,069)**	**(12.0%)**
(47,306)	**(42,237)**	**(5,069)**	**(12.0%)**	**Change in Net Assets**	**(47,306)**	**(42,237)**	**(5,069)**	**(12.0%)**

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OTHER PROGRAM INCOME STATEMENTS – JULY MONTH:

PACE

- **CHANGE IN NET ASSETS** is $0.4 million, favorable to budget $0.2 million

MSSP

- **CHANGE IN NET ASSETS** is ($105,418), favorable to budget $17,944

Covered CA

- **CHANGE IN NET ASSETS** is ($0.1) million, favorable to budget $0.6 million

NON-OPERATING INCOME STATEMENTS – JULY MONTH:

BUILDING 500 City Parkway

- **CHANGE IN NET ASSETS** is ($94,608), favorable to budget $1,794
  - Net of $127,491 in Rental Income and $222,099 in Administrative Expenses

BUILDING 7900 Garden Grove Blvd

- **CHANGE IN NET ASSETS** is ($47,306), unfavorable to budget $5,069

INVESTMENT INCOME

- Unfavorable variance of $0.4 million compared to budget driven by higher interest income of $6.0 million offset by net realized and unrealized losses on investments of $6.4 million

CalOptima Health
Balance Sheet
July 31, 2025

	July-25	June-25	$ Change	% Change
ASSETS				
Current Assets				
Cash and Cash Equivalents	373,963,314	475,203,955	(101,240,641)	(21.3%)
Short-term Investments	1,464,311,276	1,340,926,601	123,384,675	9.2%
Capitation Receivable	518,034,478	653,537,573	(135,503,095)	(20.7%)
Receivables - Other	89,705,884	95,574,162	(5,868,278)	(6.1%)
Prepaid Expenses	13,520,101	11,183,062	2,337,039	20.9%
Total Current Assets	**2,459,535,052**	**2,576,425,353**	**(116,890,300)**	**(4.5%)**
Board Designated Assets				
Board Designated Reserves	1,584,624,044	1,584,426,734	197,310	0.0%
Statutory Designated Reserves	132,296,848	132,380,774	(83,926)	(0.1%)
Total Designated Assets	**1,716,920,892**	**1,716,807,508**	**113,384**	**0.0%**
Restricted Deposit	**300,000**	**300,000**	**-**	**0.0%**
Capital Assets, Net	**102,691,674**	**98,622,705**	**4,068,969**	**4.1%**
Total Assets	**4,279,447,618**	**4,392,155,566**	**(112,707,947)**	**(2.6%)**
Deferred Outflows of Resources				
Advance Discretionary Payment	-	-	-	0.0%
Net Pension	27,437,072	27,437,072	-	0.0%
Other Postemployment Benefits	1,189,000	1,189,000	-	0.0%
Total Deferred Outflows of Resources	**28,626,072**	**28,626,072**	**-**	**0.0%**
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	**4,308,073,690**	**4,420,781,638**	**(112,707,947)**	**(2.5%)**
LIABILITIES				
Current Liabilities				
Accounts Payable	105,746,041	233,986,507	(128,240,466)	(54.8%)
Medical Claims Liability	1,048,281,485	1,047,737,339	544,146	0.1%
Accrued Payroll Liabilities	25,282,450	29,845,788	(4,563,338)	(15.3%)
Deferred Revenue	15,146,239	22,054,562	(6,908,323)	(31.3%)
Other Current Liabilities	-	-	-	0.0%
Capitation & Withholds	158,732,484	153,993,365	4,739,119	3.1%
Total Current Liabilities	**1,353,188,699**	**1,487,617,562**	**(134,428,863)**	**(9.0%)**
GASB 96 Subscription Liabilities	21,561,250	16,837,359	4,723,891	28.1%
Community Reinvestment	90,646,728	88,098,111	2,548,617	2.9%
Capital Lease Payable	241,474	245,394	(3,920)	(1.6%)
Postemployment Health Care Plan	17,256,358	17,249,000	7,358	0.0%
Net Pension Liability	5,840,992	5,840,992	-	0.0%
Total Liabilities	**1,488,735,501**	**1,615,888,418**	**(127,152,917)**	**(7.9%)**
Deferred Inflows of Resources				
Net Pension	1,321,519	1,321,519	-	0.0%
Other Postemployment Benefits	2,988,000	2,988,000	-	0.0%
Total Deferred Inflows of Resources	**4,309,519**	**4,309,519**	**-**	**0.0%**
Net Position				
Required TNE	129,265,189	129,341,855	(76,666)	(0.1%)
Funds in excess of TNE	2,685,763,481	2,671,241,846	14,521,636	0.5%
Total Net Position	**2,815,028,671**	**2,800,583,701**	**14,444,969**	**0.5%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION	**4,308,073,690**	**4,420,781,638**	**(112,707,947)**	**(2.5%)**

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BALANCE SHEET – JULY MONTH:

ASSETS of $4.3 billion decreased $112.7 million from June or 2.5%

- Capitation Receivables decreased $135.5 million primarily due to the receipt of Managed Care Organization (MCO) tax revenue from the Department of Health Care Services (DHCS) for April through June 2025
- Receivables – Other decreased $5.9 million due to receipt of pharmacy rebates
- Operating Cash and Short-Term Investments increased $22.1 million due to the receipt of MCO tax revenue from DHCS for April through June of $193.0 million, pharmacy rebates and payments from the Centers for Medicare & Medicaid Services (CMS) for Calendar Year (CY) 2025 mid-year Hierarchical Condition Category (HCC), offset by the quarterly MCO tax payment of $188.3 million
- Capital Assets, Net increased $4.1 million due to GASB 96 related activity

LIABILITIES of $1.5 billion decreased $127.2 million from June or 7.9%

- Accounts Payable decreased $128.2 million primarily due to the quarterly MCO tax payment
- Deferred Revenue decreased $6.9 million due to OneCare Part D direct subsidy experience and calculation
- Accrued Payroll Liabilities decreased $4.6 million due to the variability in the number of days in the month and the pay period timing
- Capitation and Withholds increased 4.7 million due to quality accruals

NET ASSETS of $2.8 billion, increased $14.4 million from June or 0.5%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of July 31, 2025

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	792,394,311				
MetLife Tier One	792,229,732				
Board Designated Reserves	1,584,624,044	1,052,137,734	1,683,420,374	532,486,310	(98,796,330)
Current Reserve Level (X months of average monthly revenue) [1]	*3.77*	*2.50*	*4.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	66,272,379				
MetLife Tier Two	66,024,469				
Statutory Designated Reserves	132,296,848	129,265,189	142,191,708	3,031,659	(9,894,860)
Current Reserve Level (X min. TNE) [1]	*1.02*	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

CalOptima Health
Statement of Cash Flows
July 31, 2025

	July 2025
CASH FLOWS FROM OPERATING ACTIVITIES:	
Change in net assets	14,445,015
Adjustments to reconcile change in net assets	
to net cash provided by operating activities	
Depreciation & Amortization	1,058,504
Changes in assets and liabilities:	
Prepaid expenses and other	(2,337,039)
Catastrophic reserves	
Capitation receivable	141,371,373
Medical claims liability	544,100
Deferred revenue	(6,908,323)
Payable to health networks	4,739,119
Accounts payable	(128,240,466)
Accrued payroll	(4,555,980)
Other accrued liabilities	7,268,588
Net cash provided by/(used in) operating activities	27,384,891
GASB 68 and GASB 75 Adjustments	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:	
Net Asset transfer from Foundation	-
Net cash provided by (used in) in capital and related financing activities	-
CASH FLOWS FROM INVESTING ACTIVITIES:	
Change in Investments	(123,384,675)
Change in Property and Equipment	(5,127,473)
Change in Restricted Deposit & Other	-
Change in Board Designated Reserve	(113,384)
Change in Homeless Health Reserve	-
Net cash provided by/(used in) investing activities	(128,625,532)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	(101,240,641)
CASH AND CASH EQUIVALENTS, beginning of period	$475,203,955
CASH AND CASH EQUIVALENTS, end of period	**373,963,314**

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CalOptima Health
Spending Plan
For the One Month Ending July 31, 2025

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 7/31/2025	**$2,815.0**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,584.6**			**56.3%**
	Statutory Designated Reserve[1]	**$132.3**			**4.7%**
	Capital Assets, net of Depreciation	**$102.7**			**3.6%**
Resources Allocated[3]	Homeless Health Initiative[2]	$20.7	$65.9	$45.2	0.7%
	Housing and Homelessness Incentive Program[2]	25.8	87.4	61.5	0.9%
	Intergovernmental Transfers (IGT)[3]	45.0	52.1	7.0	1.6%
	Digital Transformation and Workplace Modernization	28.4	100.0	71.6	1.0%
	CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
	CalFresh and Redetermination Outreach Strategy	1.7	6.0	4.3	0.1%
	Coalition of Orange County Community Health Centers Grant	25.7	50.0	24.3	0.9%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	General Awareness Campaign	0.3	4.7	4.4	0.0%
	Member Health Needs Assessment	0.6	1.3	0.7	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	119.0	153.5	34.5	4.2%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.4%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program Grant	3.0	5.0	2.0	0.1%
	Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program Grant	1.5	2.7	1.2	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	44.5	50.0	5.5	1.6%
	Distribution Event - Naloxone Grant	2.2	15.0	12.8	0.1%
	Garden Grove Bldg. Improvement	9.8	10.5	0.7	0.3%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.3%
	Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
	Outreach Strategy for newly eligible Adult Expansion members	3.2	7.6	4.4	0.1%
	Quality Initiatives from unearned Pay for Value Program	18.8	23.3	4.5	0.7%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.2	1.2	1.0	0.0%
	Medi-Cal Provider Rate Increases	298.2	526.2	228.0	10.6%
	Homeless Prevention and Stabilization Pilot Program	0.2	0.3	0.1	0.0%
	OneCare Member Engagement and Education	0.3	0.3	0.0	0.0%
	Subtotal:	**$700.2**	**$1,236.7**	**$536.5**	**24.9%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$295.2**			**10.5%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 169 days of CalOptima Health's current operations.

[2] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.

[3] On June 5, 2025, the Board of Directors approved the close out of Board-approved initiatives and transfer of remaining funds back to unallocated reserves.

CalOptima Health
Key Financial Indicators
As of July 31, 2025

	Item Name	July 2025				
		Actual	Budget	Variance	%	
Income Statement	Member Months	904,278	906,467	(2,189)	(0.2%)	
	Operating Revenue	396,458,146	399,374,664	(2,916,518)	(0.7%)	
	Medical Expenses	366,713,502	370,870,900	4,157,398	1.1%	
	General and Administrative Expense	20,527,877	25,599,842	5,071,965	19.8%	
	Non-Operating Income/(Loss)	5,228,202	8,194,730	(2,966,528)	(36.2%)	
	Summary of Income & Expenses	14,444,969	11,098,652	3,346,317	30.2%	
Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance		
	Consolidated	92.5%	92.9%	(0.4%)		
	Administrative Loss Ratio (ALR)	Actual	Budget	Variance		
	Consolidated	5.2%	6.4%	1.2%		

Key:	
> 0%	
> -20%, < 0%	
< -20%	

Investment	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
	@7/31/2025	3,156,008,921	3,030,032,349	125,976,572	4.2%
	Unallocated/Unassigned Reserve Balance	Current Month @ July 2025	Fiscal Year Ending June 2024	Change	%
	Consolidated	295,189,049	264,975,684	30,213,364	11.4%
	*Days Cash On Hand**	169			

*Total Designated Reserves and unallocated reserve amount can support approximately 169 days of CalOptima Health's current operations.

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CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the One Month Ending July 31, 2025

	July 2025				All Time to Date			
	Actual Spend	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**
Capital Assets (Cost, Information Only):								
Total Capital Assets	**15,000**	**-**	**(15,000)**	**0.0%**	**15,625,952**	**31,525,709**	**15,899,757**	**50.4%**
Operating Expenses:								
Salaries, Wages & Benefits	-	-	-	0.0%	17,826,058	18,084,440	258,382	1.4%
Professional Fees	228,137	250,000	21,863	8.7%	7,028,948	8,332,563	1,303,615	15.6%
Purchased Services	-	-	-	0.0%	1,332,669	1,854,000	521,331	28.1%
GASB 96 Amortization Expenses	-	-	-	0.0%	2,563,169	5,492,203	2,929,034	53.3%
Other Expenses	427,840	182,292	(245,548)	(134.7%)	21,523,581	22,639,446	1,115,865	4.9%
Medical Management	229,257	-	(229,257)	0.0%	5,731,413	2,751,078	(2,980,335)	(108.3%)
Total Operating Expenses	**885,234**	**432,292**	**(452,942)**	**(104.8%)**	**56,005,840**	**59,153,730**	**3,147,891**	**5.3%**

Funding Balance Tracking:	**Approved Budget**	**Actual Spend**	**Variance**
Beginning Funding Balance	100,000,000	100,000,000	-
Less:			
Capital Assets[1]	38,835,003	15,625,952	23,209,051
FY2023 Operating Budget[2]	8,381,011	8,381,011	-
FY2024 Operating Budget	22,788,092	22,788,092	-
FY2025 Operating Budget	24,500,000	23,951,502	548,498
FY2026 Operating Budget	5,187,500	885,234	4,302,266
Ending Funding Balance	**308,394**	**28,368,209**	**28,059,815**
Add: Prior year unspent Operating Bud	**548,498**		
Total Available Funding	**856,892**		

[1] Staff will continue to monitor the project status of DTS' Capital Assets.
[2] Unspent budget from this period is added back to available DTS funding.
[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

Note: Report includes applicable transactions for GASB 96, Subscriptions - Based Information Technology Arrangements.

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CalOptima Health
Summary of Homeless Health Initiatives (HHI) and Allocated Funds
As of July 31, 2025

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
HHI - IGT'S	64,131,301	64,131,301	45,175,789	18,955,511	-
HHI - Existing Reserves	1,800,000	1,800,000	-	1,800,000	-
HHIP	40,100,000	40,100,000	-	40,100,000	-
Total	**106,031,301**	**106,031,301**	**45,175,789**	**60,855,511**	**-**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-	IGT's
Recuperative Care	6,194,190	6,194,190	-	IGT's
Medical Respite	250,000	250,000	-	IGT's
Day Habilitation (County for HomeKey)	2,500,000	-	2,500,000	IGT's
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-	IGT's
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-	IGT's
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522	IGT's
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	925,540	37,721	IGT's
FQHC (Community Health Center) Expansion	21,902	21,902	-	IGT's
HCAP and CalOptima Health Days	9,888,914	4,335,100	5,553,813	IGT's
Vaccination Intervention and Member Incentive Strategy[1]	54,649	54,649	-	IGT's
Street Medicine[2]	14,376,652	7,618,190	6,758,462	IGT's & Existing Reserves
Outreach and Engagement	7,000,000	1,138,008	5,861,992	IGT's
Housing and Homelessness Incentive Program (HHIP)[3]	40,100,000	-	40,100,000	IGT's & Existing Reserves
Subtotal of Approved Initiatives	**106,031,301**	**45,175,789**	**60,855,511**	
Transfer of funds to HHIP[3]	(40,100,000)	-	(40,100,000)	
Program Total	**65,931,301**	**45,175,789**	**20,755,511**	

[1]On June 5, 2025 the Board of Directors approved the close out of the Vaccination Intervention and Member Incentive Strategy program and transfer of the remaining funds of $68,699 to unallocated reserves for new initiatives

[2]On March 19, 2025, CalOptima Health's Board of Directors approved $4.3 million from existing reserves to fund a new Street Medicine Program (Santa Ana). On March 7, 2024, CalOptima Health's Board of Directors approved $5.0 million to expand the Street Medicine Program. $3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and $1.8 million from existing reserves to fund 2-year agreements with Healthcare in Action (Anaheim) and Celebrating Life Community Health Center (Costa Mesa)

[3]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP

CalOptima Health
Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds
As of July 31, 2025

Summary by Funding Source:	Total Funds[1]	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	54,930,994	31,576,010	23,354,985	$18,000,195
Existing Reserves & HHI Transfer	87,384,530	87,384,530	61,543,126	25,841,404	-
Total	**160,315,719**	**142,315,524**	**93,119,136**	**49,196,389**	**18,000,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	862,350	537,650	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,696,311	925,000	HHI & DHCS
Infrastructure Projects	5,832,314	5,580,354	251,960	HHI
Capital Projects	108,247,369	73,195,575	35,051,794	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	6,929,155	3,255,375	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	**$133,185,524[1]**	**$93,119,136**	**$40,066,389**	

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments

CalOptima Health
Fiscal Year 2025-26 Budget Allocation Changes
Reporting Changes as of July 31, 2025

Transfer Month	Line of Business	From	To	Amount	Reason to Re-Allocate Funds
July	Medi-Cal	Human Resources - Training & Seminar - New: 7 Habits of Highly Effective People	Human Resources - Cert./Cont. Education - Educational Reimbursement	$90,000	For Educational Reimbursement
July	Medi-Cal	Human Resources - Professional Fees - Executive Recruiters, Direct Hire & Conversion Fees	Human Resources - Advertising - Combined: Recruitment & Job Postings Network	$90,000	For LinkedIn Advertising
July	Medi-Cal	IS - Infrastructure - Maintenance HW/SW - Oracle Software License	IS - Infrastructure - Maintenance HW/SW - Server - HP Server Maintenance	$28,150	For HP Maintenance Coverage
July	Medi-Cal	IS - Application Development - Prof Fees - Development and QA Professional Services	IS - Application Development - Purch Svcs - General - Managed Services for Website Support	$120,250	For American Eagle maintenance support

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $250,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors Meeting
September 4, 2025

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima Health's Board of Directors including, but not limited to, updates on internal and health network monitoring and audits conducted by CalOptima Health's Delegation Oversight and Internal Audit departments, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. UPDATES ON REGULATORY AUDITS

1. Medicare

a. **Contract Year (CY) 2012 Contract-Specific Risk Adjustment Data Validation (RADV) Audit (CON12 RADV) *(applicable to OneCare)***

Update

- Awaiting communication from Centers for Medicare & Medicaid Services (CMS) regarding the overpayment collection activities related to this RADV audit.

Previously Reported

- May 13, 2025 - The RADV Audit Report, Payment Error Calculation Methodology, and summary of findings were received by CalOptima Health.
- CMS calculated an overpayment amount of $54,735.41.
- Financial Analysis determined no appeal will be filed.
- CMS will send additional communications regarding overpayment collection activities related to this RADV audit once either the appeal window is closed and no appeal is submitted, or appeal processing is complete.

Background

- CMS conducted a CY2012 RADV audit of CalOptima Health contract H5433 in 2015.
- No further communications regarding the audit were received until May 13, 2025.
- The Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) program is CMS' primary way to address overpayments to Medicare Advantage Organizations (MAOs). During a MA RADV audit, CMS confirms that any diagnoses submitted by an MAO for risk adjustment are sufficiently supported in the enrollees' medical records. If diagnoses are not sufficiently supported by the medical records, CMS may collect overpayments. MA RADV audits occur after the final risk adjustment data submission deadline for the MA contract year.

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b. **CY 2019 Part C Risk Adjustment Data Validation (RADV) Audit (CON19 RADV) *(applicable to OneCare)***

Update

- The Financial Analysis team is leading the effort to retrieve relevant provider medical records for submission to CMS.
- Some medical records have been reviewed, validated and submitted to CMS and will continue until the submission window closes.

Previously Reported

- June 12, 2025 - CMS notified CalOptima Health its OneCare contract (H5433) had been selected for a Payment Year (PY) 2019 Contract-Level Risk Adjustment Data Validation (CON19 RADV) audit.
- CMS will be conducting a medical record review to validate the accuracy of a subset of PY 2019 risk adjustment data and payments associated with encounters with dates of service from January 1, 2018, through December 31, 2018.
- Medical record submission window will close on September 15, 2025.

Background

- The PY 2019 RADV audit will focus on risk adjusted payments made to Medicare Advantage Organizations (MAO) for the 2019 coverage year that CMS believes may be at higher risk for overpayments.

c. **Annual Compliance Program Effectiveness (CPE) Audit (*applicable to OneCare)***

Update

- Kick off meeting conducted 8/6/25.
- Audit Webinar Week 10/6/25 – 10/10/25.
- Independent consultant to conduct two pre-training sessions with CalOptima Health. Scheduled for 8/6/25 and 8/12/25.
- RAC Medicare requested the business areas to submit the pre-audit deliverables.

Background

- CalOptima Health is required to conduct an independent audit on the effectiveness of its Compliance program on an annual basis, and to share the results with the governing body.
- CalOptima Health engaged an independent consultant to conduct the audit to ensure that its Compliance Program is administering the elements of an effective compliance program as outlines in the CMS Medicare Part C and D Program Audit Protocols.
- The audit will start in early August, 2025 and continue through November, 2025.
- The audit review period will be from 2/3/25 through 8/1/25.

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2. Medi-Cal

a. 2025 Department of Health Care Services (DHCS) Routine Medical Audit

Update

- 6/26/25: CalOptima Health submitted its timely corrective action plan (CAP) response to DHCS.
  - DHCS accepted 1 of the 4 CAPs; 3 CAPs remain open until additional information and future deliverables are provided
- 8/1/25: Final CAP updates & deliverables submitted to DHCS. Awaiting DHCS CAP determination on the 3 open CAPs.
- **At this time, no additional deliverables are due to DHCS.**

Audit Details and Background – previously reported

- The DHCS Routine Medical Audit consisted of DHCS's review of both the Primary (aka "Main Contract") and Secondary contracts (aka "State Supported Services"). The report findings are as follows:
  - **Primary/Main Contract**
    - **4 Findings** across 3 audit categories.

Category #	Audit Area	# of Findings
1	Utilization Management	1
2	Case Management and Coordination of Care	2
3	Network and Access to Care	0
4	Member's Rights	0
5	Quality Management	0
6	Administrative and Organizational Capacity	1

  - **Secondary Contract - State Supported Services (SSS)**
    - **No Findings**

- October 23, 2024 – DHCS engaged CalOptima Health in its annual, routine medical audit.
  - The audit consisted of an evaluation of CalOptima Health's compliance with its contract and regulations in six (6) categories:
    - Utilization Management (UM)
    - Case management and coordination of care
      - New area audited in this category:
        - Enhanced Care Management (ECM)
    - Availability and accessibility
    - Member's rights
    - Quality management
    - Administrative and organizational capacity
      - New area audited in this category:
        - Encounters
  - New areas audited

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- Enhanced Care Management (ECM)
- Encounters

- The audit was considered a limited-scope audit and required the participation of two (2) CalOptima Health Networks: Children's Hospital of Orange County Health Alliance (CHOC) and Optum for UM only
- Onsite interviews were conducted with CalOptima Health staff, including Medical Director, Director of Quality Management, Director of Utilization Management, Member Services Manager, Provider Relations Manager, Health Education Coordinator, Grievance Coordinator, and other staff as necessary.
- The audit involved a review of pre-onsite documents, staff interviews and medical record review.

➢ January 27, 2025 through January 29, 2025 – DHCS conducted the onsite visit with an Entrance Conference and conducted staff interviews throughout the rest of the onsite visit.

➢ 5/27/25: DHCS finalized its draft report and CalOptima Health received its formal CAP Request from DHCS.
- The report was consistent with the draft report with four findings.

B. REGULATORY NOTICES OF NON-COMPLIANCE

➢ CalOptima Health did not receive any notices of non-compliance from its regulators for the month of August 2025.

C. UPDATES ON HEALTH NETWORK MONITORING AND AUDITS

➢ AMVI Care Medical Group, Prospect Medical Group, & United Care Medical Group
- Managed by Astrana Health, Management Services Organization (MSO)
- Lookback July 1, 2024, to February 28, 2025

D. INTERNAL AUDIT DEPARTMENT (IAD)

a. Internal Annual Audits in Process
➢ 2025 Case Management (OneCare)
➢ 2025 Claims Administration (Medi-Cal)

b. Internal Annual Audits Completed
➢ 2024 Behavioral Health (BH) (Medi-Cal)- closed on 7/1/25

c. Ad Hoc Internal Audits
➢ CalAIM Community Supports Housing Transition and Navigation Services (in process)
➢ CalAIM Community Supports Program Oversight Practices (in process)

d. Board-Approved Grants and Initiatives Review
Grants currently under review include:
➢ Be Well/Mind OC, Irvine
- Grant is in process
- Review to resume upon close of grant

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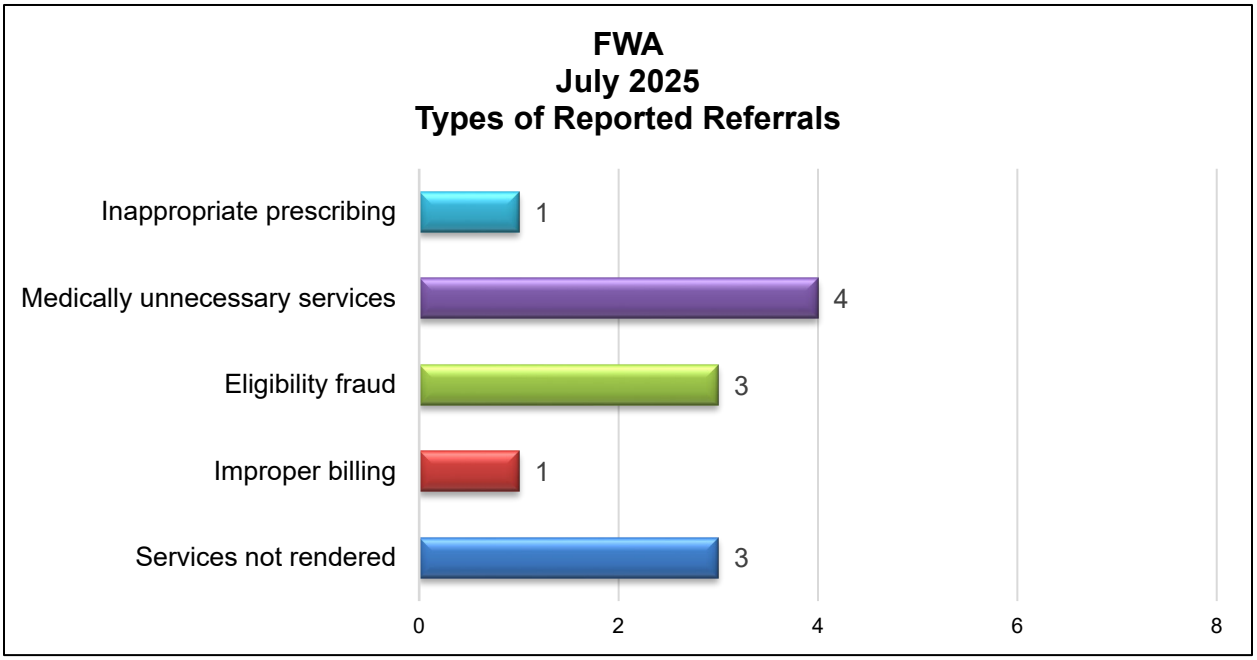
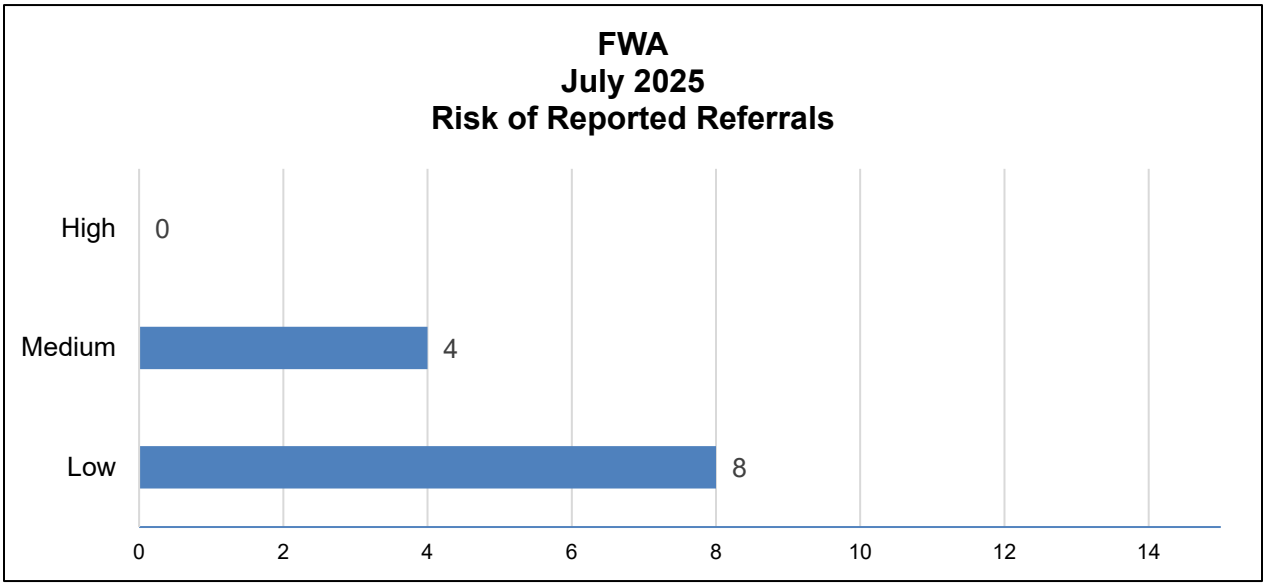
E. FRAUD, WASTE & ABUSE (FWA) INVESTIGATIONS





Total Number of New Cases Referred to DHCS (State)	12
Total Number of New Cases Referred to DHCS and CMS	7
Total Number of Referrals Reported	**12**

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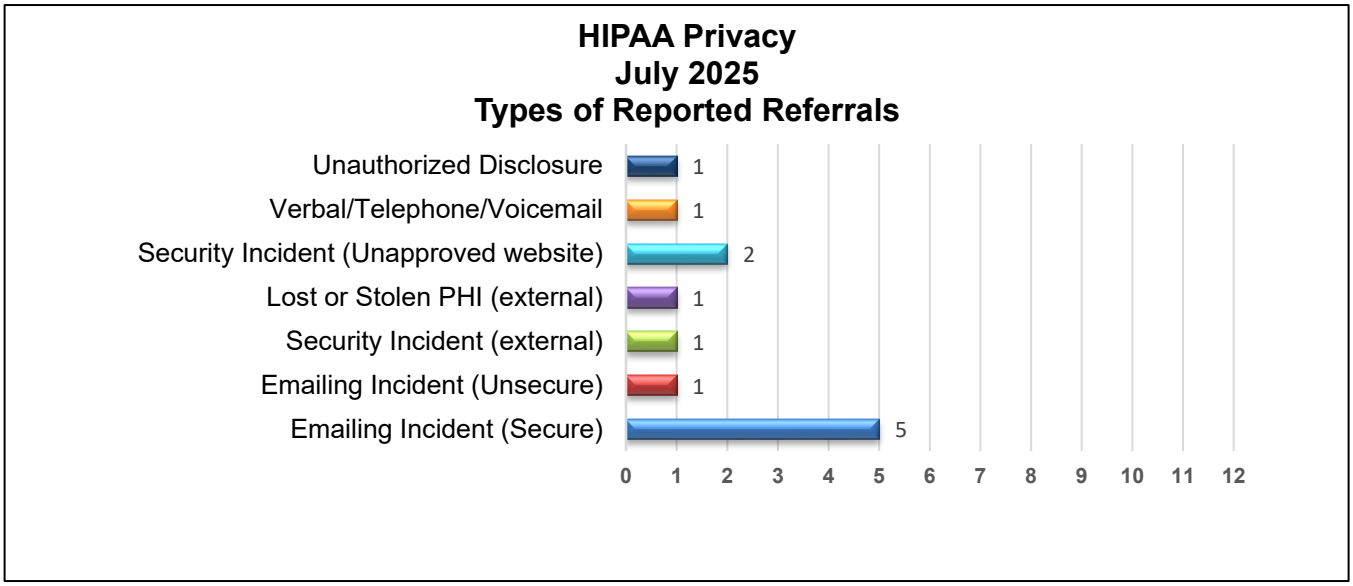
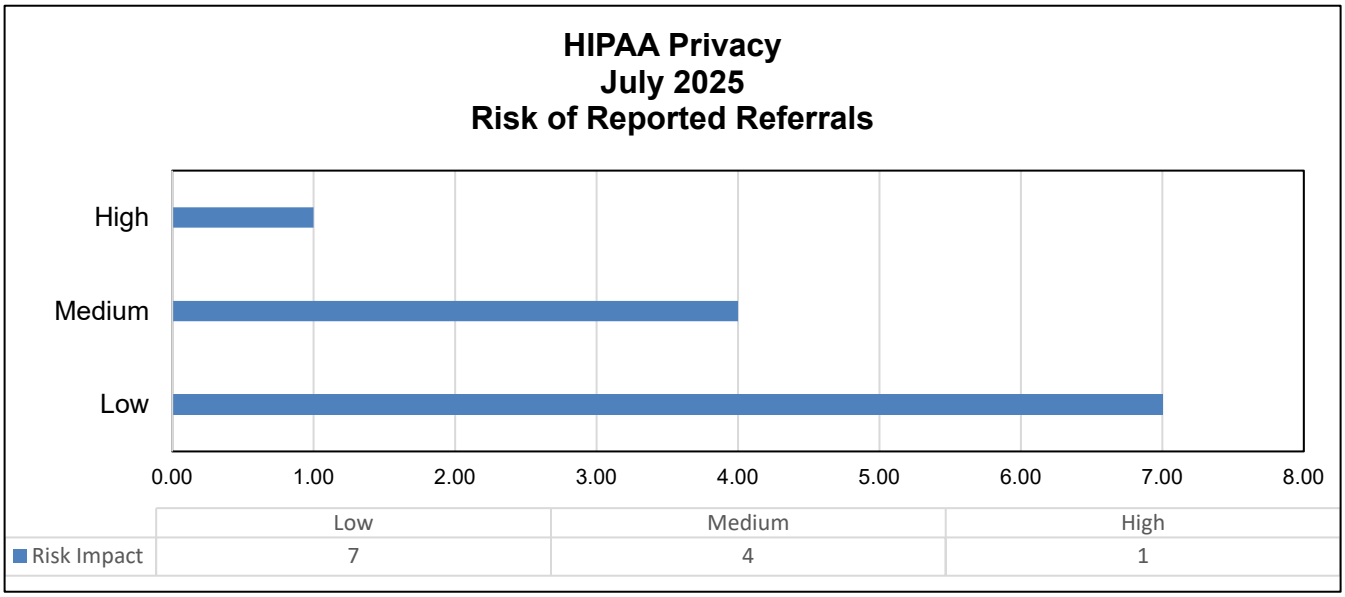
F. PRIVACY UPDATE





Total Number of Referrals Reported to DHCS (State)	12
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	1

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CHAMBER HILL

MEMORANDUM

TO: CalOptima Health
Board of Directors

FROM: Chamber Hill Strategies

DATE: August 22, 2025

SUBJECT: Board of Directors Report – September 2025

Congress Out of Session, Outreach Highlights CalOptima Health Events

While the U.S. Senate and House of Representatives took scheduled breaks from legislative sessions in August, CalOptima Health and Chamber Hill Strategies (CHS) continued to be in regular contact with offices representing CalOptima Health and Orange County in Congress. CHS highlighted CalOptima Health-supported events in Orange County for all delegation offices. In addition, CHS invited all delegation offices to join the August 27 webinar, "Understanding The Impact of Medi-Cal Changes on Orange County's Health Care Landscape," which included CalOptima Health CEO Michael Hunn and other Orange County leaders. Offices contacted included: Sen. Alex Padilla (D-CA), Sen. Adam Schiff (D-CA), Rep. Lou Correa (D-CA-46), Rep. Young Kim (R-CA-40), Rep. Derek Tran (D-CA-45), Rep. Dave Min (D-CA-47), Rep. Linda Sanchez (D-CA-38), and Rep. Mike Levin (D-CA-49).

HHS, CMS Announce Call for Nominations for New Healthcare Advisory Committee

On August 21, the U.S. Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS) announced a call for nominations to serve on a newly created federal Healthcare Advisory Committee. The announcement encourages individuals with expertise in chronic disease prevention and management, federally administered health care financing, and delivery system reform to apply. The Committee will be comprised of 15 members and will be tasked with making recommendations to HHS Secretary Robert F. Kennedy, Jr. and CMS Administrator Mehmet Oz, MD "to improve how care is financed and delivered across Medicare, Medicaid and the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace." Individuals may either be self-nominated or be nominated by an organization. Details regarding the nomination process are outlined in the Federal Register. Nominations are due September 22, and appointments will be announced later this year.

Court Halts Sharing of Medicaid Enrollee Information with Immigration Enforcement

On August 12, a federal judge in the Northern District of California issued a ruling temporarily blocking the sharing of Medicaid recipients' information with immigration enforcement agencies. The ruling was in response to a lawsuit filed by California Attorney General Rob Bonta and 19 other states. The ruling followed an announcement on July 17 that CMS would be sharing the data of all 79 million Medicaid recipients with Immigration & Customs Enforcement (ICE). The ruling and temporary stay only applies to California and the other 19 states joining the case.

CMS Announces Monthly Review of Medicaid Immigration Status

On August 19, the CMS announced the launch of an initiative to review the immigration status of enrollees in Medicaid and CHIP. Under the initiative, CMS will provide monthly reports to states that will identify individuals whose citizenship or immigration status could not be confirmed through federal databases. CMS provided the first set of reports on August 19, and all states will be receiving reports over the next month. CMS stated that states are responsible for reviewing cases and are expected to take action to modify coverage or enforce non-citizen eligibility rules. CHS has been in contact with key offices, including Rep. Young Kim (R-CA-40) and Rep. David Valadao (R-CA-22), regarding concerns and potential effects of these policy changes.

MAHA Strategy Draft Outlines Efforts to Promote Nutrition and Fitness for Children

On August 15, the draft of a strategy document titled "Make Our Children Healthy Again" was leaked to reporters and the health policy community. The draft was prepared by the Make America Healthy Again (MAHA) Commission and submitted to the White House earlier in the same week. Among its recommendations, the strategy would call on CMS and states to partner in developing measures for Medicaid managed care organizations that would "promote measurable health improvements through nutrition coaching and other fitness indicators." In addition, the strategy recommends that CMS support state CHIP programs in promoting prevention and wellness for children. The strategy also outlines efforts to address the roots of chronic diseases in children and includes recommendations for several initiatives, including the promotion of breastfeeding, healthy foods, nutrition, and fitness across multiple agencies and a range of government programs, including the Supplemental Nutrition Assistance Program (SNAP).

Rumors about Second Budget Reconciliation Bill, But Outlook Unclear

With the enactment of the "One Big Beautiful Bill Act" (H.R. 1, OBBBA), some in Congress are expressing interest in pursuing a second reconciliation package. The House Republican Study Committee (RSC), a coalition of conservative House Republicans, has initiated early conversations, and this included the RSC hosting a "reconciliation 2.0" briefing in August to discuss the possibility for additional reconciliation legislation either this year or in 2026. At the briefing, the Paragon Health Institute, a conservative think tank, presented and highlighted proposals for potential inclusion in future reconciliation legislation including, but not limited to, reforming enhanced premium tax credits (EPTCs) for coverage on the health insurance marketplace, modifying the federal medical assistance percentage (FMAP) down from the 90/10 match for the expansion population, and pursuing various Medicare and Medicare Advantage (MA) reforms. These conversations aside, it is unclear how much support an effort

would garner among House and Senate Republicans. In addition, the House and Senate Budget Committees reportedly are far from having a plan for another budget or budget reconciliation process.

CALOPTIMA HEALTH – STATE LEGISLATIVE REPORT
August 22, 2025

General Update

The Legislature reconvened from summer recess on August 18. The first week back was dominated by efforts to pass a midterm congressional redistricting initiative, intended to counter Texas' redistricting moves that favor Republicans in Congress. The California Legislature had to move fast because of an August 22 deadline to make the November 4 special election, when voters will decide the fate of Proposition 50. The Legislature did so, and the Governor signed the required legislation on August 21, collectively naming the three-bill package the "Election Rigging Response Act":

1) ACA 8 – Assembly Constitutional Amendment which authorized a special election and override of the Citizens Redistricting Commission
2) AB 604 – adopts and formalizes the proposed Democratic-favoring legislative congressional map to be voted on
3) SB 280 – funds and implements the logistics of holding the special election in November

State Republican lawmakers did file an emergency lawsuit with the California Supreme Court alleging the Legislature violated the state constitution by not observing a mandatory 30-day wait period. The court denied that challenge, stating "the burden of establishing a basis for relief failed at this time." While legal experts anticipate Democrats will ultimately win on this issue, there will surely continue to be legal challenges.

The week of August 25 will focus on the suspense file, when hundreds of bills with a fiscal impact will be acted upon on August 29. The final two weeks of session will be spent considering and voting on measures released from the suspense file before lawmakers recess for the year on September 12. In addition to these priorities, the Legislature will also devote attention to the impact of recent ICE raids, inappropriate sharing of health data, and potential responses to federal Medicaid cuts in H.R. 1.

Budget Update

This week, the Senate and Assembly Health Committees held a joint informational hearing to discuss the impact of federal action on community healthcare. This hearing not only focused on the financial cuts impacting California's Medi-Cal system through H.R. 1, but also discussed immigration enforcement impacts and the sharing of sensitive healthcare data. While there were no surprises that arose from the hearing, the impending harm to California is now coming into focus. The discussion focused on the following three issue areas:

Impacts of H.R. 1 to Medi-Cal – Up to 3.4 million Medi-Cal members may lose coverage, $30 billion-plus in federal funding is at risk annually, and there will be major disruptions to Medi-Cal financing structure safety nets. The major categories of disruptions include: eligibility and access requirements; state financing restrictions with provider taxes, state directed payments and federal repayment penalties; Immigrant Coverage Limitations; and a ban on abortion providers who provide healthcare services for women.

Community Health Impacts of Immigration Enforcement Actions – In January, the Department of Homeland Security (DHS) reversed guidance requiring ICE to refrain from enforcement actions in sensitive locations such as hospitals, clinics, doctors' offices, urgent care centers, and others. This has had a chilling effect on the delivery of health care to sensitive populations who have been intimidated from seeking basic medical care. Patients are skipping chronic-care management, routine childhood checkups, and childhood vaccinations, and they are not picking up prescriptions in pharmacies. This will result in more emergency room visits and deaths.

Federal Administrative Changes Related to Access and Data Sharing – In June, DHCS learned that federal HHS had transferred Medicaid data files of millions of beneficiaries to DHS for the purpose of immigration actions, over objections of career staff who believed this to be a violation of federal law. This has caused confusion and fear in the immigrant community. California led a group of 20 states who sued the Trump Administration to prevent this unlawful use. On August 12, the states obtained a preliminary injunction to stop the use of data for immigration purposes. The courts stated there was a strong reliance interest that can be changed only by a reasoned decision-making process. The preliminary injunction will remain in place until 14 days after that process occurs.

PACE Proposed Changes – CalOptima Health joined CalPACE in officially opposing an annual maintenance fee and a PACE Rate Cap. The final budget included no annual maintenance fee. The PACE Rate Cap was deferred to January 2027, providing time for continued advocacy and planning should the Rate Cap move forward. CalOptima Health (through Clear Advocacy) was helpful in securing signatures of nine Orange County delegation members in a joint letter to legislative leadership in support of PACE programs.

Key Legislation Updates

Street Medicine – AB 543 (González-D) – Full-scope presumptive eligibility for individuals experiencing homelessness with no share of cost; would also allow a Medi-Cal member who is experiencing homelessness (or at-risk) to seek Medi-Cal covered services directly from any Medi-Cal provider. The bill sponsor accepted an amendment by the Local Health Plans of California (LHPC) requiring providers to contract with plans. The bill will be heard at the Senate suspense hearing on August 29.

Behavioral Health Data Sharing – AB 618 (Krell-D) – Co-sponsored by LHPC and the County Behavioral Health Directors Association, this bill would require sharing of data between Medi-Cal delivery systems - including managed care plans, county mental health plans and the Medi-Cal drug program for the coordination of behavioral health services. CalOptima Health sent a letter in support of the bill. The bill will be heard at the Senate suspense hearing on August 29.

Prior Authorization – SB 306 (Becker-D) – Would prohibit health plans from imposing prior authorization on a covered service for a period of one year, if 90% or more of requests for that service were approved in the prior year. SB 306 passed the Senate Floor and the Assembly Health Committee unanimously. The bill was amended in Assembly Appropriations on July 17 at the last minute as a "Special Order of Business." The amendments exempted Medi-Cal managed care plans, leading LHPC to pull their opposition. CAHP remains opposed until the amendments are further understood. It will be considered at the Senate suspense hearing on August 29.

Community Provider Preference for Enhanced Care Management (ECM) – SB 324 (Menjivar-D) – Senate President Pro Tem Mike McGuire-D is a Principal Co-author. This bill requires a Medi-Cal managed care plan, for purposes of covering the ECM benefit, or if it elects to cover a Community Support, to give preference to contracting with community providers, when they are available in the county and have the applicable ECM or Community Support experience. SB 324 was amended in Assembly Appropriations on July 3 to broaden the language to allow more flexibility for managed care plans and will be heard at the Assembly suspense hearing on August 29.

California's Essential Health Benefits (EHBs) – SB 62 (Menjivar-D) – Proposed EHB coverage expansion includes fertility treatments (including in-vitro fertilization); annual hearing exams and hearing aids; and mobility devices (walkers, wheelchairs and scooters). SB 62 codifies the proposed changes in advance of the EHB application approval by CMS. The effective date of the new plan, if approved, is January 2027. The bill passed the Senate Floor on May 27 and the Assembly Health Committee on July 15, both unanimously. This passed the Assembly Appropriations Committee on August 20 and is headed to the Assembly Floor for its final vote.

2025–26 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
SB 483 Stern	**Mental Health Diversion:** Would require that a court be satisfied that a recommended mental health treatment program is consistent with the underlying purpose of mental health diversion and meets the specialized treatment needs of the defendant. ***Potential CalOptima Health Impact*:** Increased oversight of behavioral health treatment for members.	**07/16/2025** Passed Assembly Public Safety Committee; referred to Assembly Appropriations Committee **06/04/2025** Passed Senate floor	CalOptima Health: Watch
SB 626 Smallwood-Cuevas	**Maternal Mental Health Screenings and Treatment:** Would require a licensed health care practitioner who provides perinatal care for a patient to screen, diagnose and treat the patient for a maternal mental health condition. ***Potential CalOptima Health Impact:*** Increased access to behavioral health services for eligible members.	**07/15/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **06/02/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose
SB 812 Allen	**Qualified Youth Drop-In Center Health Care Coverage:** Would require a health plan to provide coverage for mental health and substance use disorders at a qualified youth drop-in center, defined as a center providing behavioral or primary health and wellness services to youth 12 to 25 years of age with the capacity to provide services before and after school hours and that has been designated by or embedded with a local educational agency or institution of higher education. ***Potential CalOptima Health Impact*:** Increased access to behavioral health services for CalOptima Health Medi-Cal youth members.	**07/16/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/28/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Concerns
AB 37 Elhawary	**Behavioral Health Workforce:** Would require the California Workforce Development Board to study how to expand the workforce of mental health service providers providing services to homeless persons. ***Potential CalOptima Health Impact*:** Increased access to behavioral health services for members experiencing homelessness.	**03/13/2025** Referred to Assembly Labor and Employment Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 348 Krell	**Full-Service Partnership:** Would establish 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.	**06/11/2025** Passed Senate Health Committee; referred to Senate floor **05/12/2025** Passed Assembly floor	CalOptima Health: Watch
AB 384 Connolly	**Inpatient Prior Admission Authorization:** Would prohibit a health plan from requiring prior authorization for admission to medically necessary 24-hour care in inpatient settings, including general acute care hospitals and psychiatric hospitals, for mental health and substance use disorders (SUDs) as well as for any medically necessary services provided to a beneficiary while admitted for that care. ***Potential CalOptima Health Impact*:** Modified utilization management (UM) procedures for covered Medi-Cal benefits.	**04/22/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
AB 423 Davies	**Disclosures for Alcoholism, Drug Abuse Recovery or Treatment Programs and Facilities:** Would mandate a business-operated recovery residence to register its location with the California Department of Health Care Services (DHCS). ***Potential CalOptima Health Impact*:** Increased oversight for members who have received SUD treatment.	**02/18/2025** Referred to Assembly Health Committee	CalOptima Health: Watch
AB 618 Krell	**Behavioral Health Data Sharing:** Would require each Medi-Cal managed care plan (MCP), county specialty mental health plan (MHP) and Drug Medi-Cal program to electronically share data for its members to support coordination of behavioral health services. Would also require the DHCS, in consultation with the California Health and Human Services Agency (CalHHS), to determine minimum data elements and the frequency and format of data sharing through a stakeholder process and guidance, with final guidance to be published by January 1, 2027. ***Potential CalOptima Health Impact*:** Increased coordination between Medi-Cal delivery systems regarding behavioral health services.	**07/07/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/03/2025** Passed Assembly floor	**05/07/2025** CalOptima Health: SUPPORT LHPC: Sponsor

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 877 Dixon	**Nonmedical SUD Treatment:** Would require DHCS and the California Department of Managed Health Care (DMHC) to send a letter to the chief financial officer of every health plan (including a Medi-Cal MCP) that provides SUD coverage in residential facilities. The letter must inform the plan that SUD treatment in licensed or unlicensed facilities is almost exclusively nonmedical, with rare exceptions, including for billing purposes. These provisions would be repealed on January 1, 2027. ***Potential CalOptima Health Impact*:** Enhanced transparency and clarity around nonmedical treatment provided for SUDs.	**03/03/2025** Referred to Assembly Health Committee	CalOptima Health: Watch
AB 951 Ta	**Autism Diagnosis:** Would prohibit a health plan from requiring an enrollee previously diagnosed with pervasive developmental disorder or autism to receive a diagnosis to maintain coverage for behavioral health treatment for their condition. ***Potential CalOptima Health Impact*:** Increased access to care for specific behavioral health treatments.	**07/30/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Budget			
H.R. 1 Arrington (TX)	**One Big Beautiful Bill Act:** Makes substantial changes to Medicaid program funding and policies, including but not limited to the following: • Work, community service and/or education requirement of 80 hours per month for able-bodied adults without dependents (with exceptions for pregnant women, foster youth, medically frail, caregivers and others), effective December 31, 2026, or no later than December 31, 2028 • Increased frequency of eligibility redeterminations for Medicaid Expansion (MCE) enrollees from annually to every six months, effective December 31, 2026 • Emergency Medicaid services provided to all undocumented beneficiaries subject to the traditional Federal Medical Assistance Percentage (FMAP) — 50% in California — regardless of the FMAP for which those would otherwise be eligible, effective October 1, 2026 Cost-sharing for MCE enrollees with incomes of 100–138% Federal Poverty Level (FPL), not to exceed $35 per service and 5% of total income, and not to be applied to primary, prenatal, pediatric, or emergency care, effective October 1, 2028 • Prohibition on any new or increased provider taxes, effective immediately • Significant restrictions on current Managed Care Organization (MCO) taxes, which could effectively repeal California's MCO tax that was recently made permanent by Proposition 35 (2024), with a potential winddown period of up to three fiscal years (FYs) ***Potential CalOptima Health Impact*:** Reduced funding to CalOptima Health and contracted providers; decreased number of members; increased administrative costs; implementation of co-pay systems; increased financial and administrative burdens for some existing members; decreased health care utilization by some existing members; reduced benefits for some existing members. A separate overview is also enclosed.	**07/04/2025** Signed into law	**05/20/2025** CalOptima Health: OPPOSE
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

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:** Consolidates and enacts certain budget trailer bill language containing policy changes needed to implement health-related budget expenditures. Provisions related to the Medi-Cal program include but are not limited to the following: • Enrollment freeze for undocumented individuals 19 years or older, effective no sooner than January 1, 2026, with exceptions for pregnant individuals • Implementation of $30 monthly premiums for undocumented individuals ages 19-59, effective no sooner than July 1, 2027 • Reinstatement of the asset limit at $130,000 for individuals, adding $65,000 for each additional household member, capping at 10 members, effective January 1, 2026 • Enacts PACE provider sanctions, effective immediately ***Potential CalOptima Health Impact:*** An overview of the FY 2025–26 Enacted State Budget is enclosed.	**06/30/2025** Signed into law	CalOptima Health: Watch
California Advancing and Innovating Medi-Cal (CalAIM)			
SB 324 Menjivar	**Enhanced Care Management (ECM) and Community Supports Contracting:** Would require a Medi-Cal MCP to give preference to contracting with community providers that demonstrate capability of providing access and meeting quality requirements when covering the ECM benefit and/or Community Supports. In addition, would require DHCS to develop standardized templates to be used by MCPs. Would also require DHCS to develop guidance to allow community providers to subcontract with other community providers. ***Potential CalOptima Health Impact*:** Increased collaboration with community providers and standardized contracts.	**07/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/27/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Watch LHPC: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 543 Gonzalez	**Street Medicine:** Would authorize a Medi-Cal MCP to elect to offer Medi-Cal covered services through a street medicine provider. MCPs that elect to do so would be required to allow a Medi-Cal beneficiary who is experiencing homelessness to receive those services directly from a contracted street medicine provider, regardless of the beneficiary's network assignment. Additionally, would require the MCP to allow a contracted street medicine provider enrolled in Medi-Cal to directly refer the beneficiary for covered services within the appropriate network and share that information with the relevant county for inclusion in CalSAWS. ***Potential CalOptima Health Impact*:** Continued access to street medicine services for members experiencing homelessness.	**06/18/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/02/2025** Passed Assembly floor	CalOptima Health: Watch CAHP: Watch
Covered Benefits			
SB 40 Wiener	**Insulin Coverage:** Would prohibit a health plan, effective January 1, 2026 (or a policy offered in the individual or small group market, effective January 1, 2027), from imposing a copayment or other cost sharing of more than $35 for a 30-day supply of an insulin prescription drug or imposing a deductible, coinsurance, or any other cost sharing on an insulin prescription drug. Additionally, would require a health plan to cover all types of insulin without step therapy on and after January 1, 2026. ***Potential CalOptima Health Impact:*** Decreased out-of-pocket costs for future members enrolled in Covered California line of business; new UM procedures.	**08/20/2025** Passed Assembly Appropriations Committee; referred to Assembly floor **07/15/2025** Passed Assembly Health Committee **05/28/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 62 Menjivar **AB 224** Bonta	**Essential Health Benefits (EHBs):** Would express the intent of the Legislature to review California's EHB benchmark plan and establish a new benchmark plan for the 2027 plan year. Additionally, upon approval from the United States Department of Health and Human Services and by January 1, 2027, would require the new benchmark plan include certain additional benefits, including coverage for fertility services, hearing aids and exams, and durable medical equipment. ***Potential CalOptima Health Impact:*** New covered benefits for future members enrolled in Covered California line of business.	**08/20/2025** SB 62 passed Assembly Appropriations Committee; referred to Assembly floor **07/15/2025** SB 62 passed Assembly Health Committee **05/27/2025** SB 62 passed Senate floor **07/16/2025** AB 224 passed Senate Health Committee; referred to Senate Appropriations Committee **05/29/2025** AB 224 passed Assembly floor	CalOptima Health: Watch CAHP: Concerns
SB 535 Richardson **AB 575** Arambula	**Obesity Care Access Act:** Would require an individual or group health care plan that provides coverage for outpatient prescription drug benefits to cover at least one specified anti-obesity medication and bariatric surgery for the treatment of obesity. ***Potential CalOptima Health Impact:*** Expanded covered benefits for future members enrolled in Covered California line of business.	**07/15/2025** SB 535 passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/28/2025** SB 535 passed Senate floor **02/24/2025** AB 575 referred to Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 242 Boerner	**Genetic Disease Screening:** Would expand statewide newborn screenings to include Duchenne muscular dystrophy by January 1, 2027. ***Potential CalOptima Health Impact:*** Expanded covered benefits for members.	**04/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 298 Bonta	**Cost-Sharing Under Age 21:** Effective January 1, 2026, would prohibit a health plan from imposing a deductible, coinsurance, copayment, or other cost-sharing requirement for in-network health care services provided to an individual under 21 years of age, with certain exceptions for high deductible health plans that are combined with a health savings account. ***Potential CalOptima Health Impact:*** Increased costs for CalOptima Health; decreased costs for future members enrolled in Covered California line of business under 21 years of age.	**02/10/2025** Referred to Assembly Health Committee	CalOptima Health: Watch
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.	**07/02/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/02/2025** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 432 Bauer-Kahan	**Menopause:** Would require a health plan that covers outpatient prescription drugs to provide coverage for evaluation and treatment options for symptoms of perimenopause and menopause. Would also require a health plan to annually provide clinical care recommendations for hormone therapy to all contracted primary care providers who treat individuals with perimenopause and menopause. ***Potential CalOptima Health Impact:*** New covered benefits for members; increased communications to providers.	**07/16/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **07/07/2025** Passed Senate Business, Professions and Economic Development Committee **06/03/2025** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 636 Ortega	**Diapers:** Would add diapers as a covered Medi-Cal benefit for the following individuals, contingent upon an appropriation by the Legislature: • Children greater than three years of age diagnosed with a condition that contributes to incontinence • Other individuals under 21 years of age to address a condition pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standards ***Potential CalOptima Health Impact:*** New covered benefit for pediatric members.	**04/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Eligibility and Enrollment			
AB 315 Bonta	**Home and Community-Based Alternatives (HCBA) Waiver:** Would remove the cap on the number of HCBA Waiver slots and instead require DHCS to enroll all eligible individuals who apply for HCBA Waiver services. By March 1, 2026, would require DHCS to seek any necessary waiver amendments to ensure there is sufficient capacity to enroll all individuals currently on a waiting list. Would also require DHCS by March 1, 2026, to submit a rate study to the Legislature addressing the sustainability, quality and transparency of rates for the HCBA Waiver. ***Potential CalOptima Health Impact*:** Expanded member access to HCBA Waiver services.	**03/25/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 974 Patterson	**Managed Care Enrollment Exemption:** Would exempt any dual-eligible and non-dual-eligible beneficiaries who receive services from a regional center and who use the Medi-Cal fee-for-service delivery system as a secondary form of health care coverage from mandatory enrollment in a Medi-Cal MCP. ***Potential CalOptima Health Impact:*** Decreased number of members.	**04/22/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 1012 Essayli	**Unsatisfactory Immigration Status:** Would make an individual who does not have satisfactory immigrant status ineligible for Medi-Cal benefits. In addition, would transfer funds previously appropriated for such eligibility to a newly created Serving our Seniors Fund to restore and maintain payments for Medicare Part B premiums for eligible individuals. ***Potential CalOptima Health Impact:*** Decreased number of members.	**02/21/2025** Introduced	CalOptima Health: Watch
AB 1161 Harabedian	**State of Emergency Continuous Eligibility:** Would require DHCS and the California Department of Social Services to provide continuous eligibility for its applicable programs (including Medi-Cal and CalFresh) to all beneficiaries within a geographic region who have been affected by a state of emergency or a health emergency. ***Potential CalOptima Health Impact*:** Extended Medi-Cal eligibility for certain members.	**04/29/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **04/08/2025** Passed Assembly Human Services Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Operations and Administration			
SB 278 Cabaldon	**Health Data HIV Test Results:** Would authorize disclosures of HIV test results that identify or include identifying characteristics of a Medi-Cal beneficiary without written authorization of the member or their representative to the MCP for quality improvement efforts such as value-based payment and incentive programs. ***Potential CalOptima Health Impact:*** Increased quality oversight of HIV program development.	**07/16/2025** Passed Assembly Privacy and Consumer Protection Committee; referred to Assembly Appropriations Committee **06/17/2025** Passed Assembly Health Committee **05/29/2025** Passed Senate floor	CalOptima Health: Watch
SB 497 Wiener	**Legally Protected Health Care Activity:** Would prohibit a health care provider, health plan, or contractor from releasing medical information related to a person seeking or obtaining gender-affirming health care or mental health care in response to a criminal or civil action. Would also prohibit these entities from cooperating with or providing medical information to an individual, agency, or department from another state or to a federal law enforcement agency or in response to a foreign subpoena. ***Potential CalOptima Health Impact:*** Increased protection of medical information related to gender-affirming care; increased staff training regarding disclosure processes.	**07/15/2025** Passed Assembly Public Safety Committee; referred to Assembly Appropriations Committee **06/17/2025** Passed Assembly Judiciary Committee **06/02/2025** Passed Senate	CalOptima Health: Watch
SB 530 Richardson	**Medi-Cal Time and Distance Standards:** Would extend current Medi-Cal time and distance standards until January 1, 2029. In addition, would require a Medi-Cal MCP to ensure that each subcontractor network complies with certain appointment time standards and incorporate into reporting to DHCS, unless already required to do so. Additionally, the use of telehealth providers to meet time or distance standards would not absolve the MCP of responsibility to provide a beneficiary with access, including transportation, to in-person services if the beneficiary prefers. ***Potential CalOptima Health Impact:*** Increased oversight of contracted providers; increased reporting to DHCS.	**07/15/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/29/2025** Passed Senate floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 660 Menjivar	**California Health and Human Services Data Exchange Framework (DxF):** Would require the Center for Data Insights and Innovation within California Health and Human Services Agency (CalHHS) to absorb all functions related to the DxF initiative, including the data sharing agreement and policies and procedures, by January 1, 2026. Additionally, would expand DxF to include social services information. ***Potential CalOptima Health Impact:*** Increased care coordination with social service providers.	**07/16/2025** Passed Assembly Privacy and Consumer Protection Committee; referred to Assembly Appropriations Committee **07/01/2025** Passed Assembly Health Committee **06/02/2025** Passed Senate floor	CalOptima Health: Watch
AB 45 Bauer-Kahan	**Reproductive Data Privacy:** Would prohibit the collection, use, disclosure, sale, sharing, or retention of the information of a person who is physically located at, or within a precise geolocation of, a family planning center, except any collection or use necessary to perform services or provide goods that have been requested. Would also authorize an aggrieved person to institute and prosecute a civil action against any person or organization in violation of these provisions. ***Potential CalOptima Health Impact:*** Increased safeguards regarding reproductive health information.	**07/15/2025** Passed Senate Judiciary Committee; referred to Senate Appropriations Committee **06/03/2025** Passed Assembly floor	CalOptima Health: Watch
AB 257 Flora	**Specialty Telehealth Network Demonstration:** Would require the establishment of a demonstration project or grant program for a telehealth and other virtual services specialty care network designed to serve patients of safety-net providers. ***Potential CalOptima Health Impact:*** Expanded member access to telehealth specialists.	**03/25/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
AB 316 Krell	**Artificial Intelligence Defenses:** Prohibits a defendant that developed or used artificial intelligence from asserting a defense that artificial intelligence autonomously caused the alleged harm to the plaintiff. ***Potential CalOptima Health Impact:*** Increased liability related to UM procedures.	**06/24/2025** Passed Senate Judiciary Committee; referred to Senate Appropriations Committee **05/19/2025** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 403 Ortega	**Medi-Cal Community Health Service Workers:** Would require DHCS to annually review the Community Health Worker (CHW) benefit and present an analysis to the Legislature beginning July 1, 2027. The analyses would include an assessment of Medi-Cal MCP outreach and education efforts, CHW utilization and services, demographic disaggregation of the CHWs and beneficiaries receiving services, and fee-for-service reimbursement data. ***Potential CalOptima Health Impact:*** New reporting requirements to DHCS.	**03/25/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 577 Wilson	**Prescription Drug Antisteering:** Would prohibit a health plan or pharmacy benefit manager (PBM) from engaging in specified steering practices, including requiring an enrollee to use a retail pharmacy for dispensing prescription oral medications and imposing any requirements, conditions or exclusions that discriminate against a physician in connection with dispensing prescription oral medications. Additionally, would require a health care provider, physician's office, clinic or infusion center to obtain consent from an enrollee and disclose a good faith estimate of the applicable cost-sharing amount before supplying or administering an injected or infused medication. ***Potential CalOptima Health Impact:*** Increased oversight of contracted PBM and referral processes.	**04/29/2025** Passed Assembly Health Committee; referred to Assembly Appropriatons Committee	CalOptima Health: Watch
AB 688 Gonzalez	**Telehealth for All Act of 2025:** Beginning in 2028 and every two years thereafter, would require DHCS to use Medi-Cal data and other data sources to produce analyses in a publicly available Medi-Cal telehealth utilization report. ***Potential CalOptima Health Impact:*** New reporting requirements to DHCS.	**07/02/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/02/2025** Passed Assembly floor	CalOptima Health: Watch
AB 980 Arambula	**Health Plan Duty of Care:** As it pertains to the required "duty of ordinary care" by a health plan, would define "medically necessary health care service" to mean legally prescribed medical care that is reasonable and comports with the medical community standard. ***Potential CalOptima Health Impact:*** Modified UM procedures.	**04/22/2025** Re-referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Older Adult Services			
SB 242 Blakespear	**Medicare Supplemental Coverage Open Enrollment Periods:** Would make Medicare supplemental benefit plans available to qualified applicants with end stage renal disease under the age of 64 years. Would also create an annual open enrollment period for Medicare supplemental benefit plans and prohibit such plans from denying an application or adjusting premium pricing due to a preexisting condition. Additionally, would authorize premium rates offered to applicants during the open enrollment period to vary based on the applicant's age at the time of issue, but would prohibit premiums from varying based on age after the contract is issued. ***Potential CalOptima Health Impact:*** Expanded Medicare coverage options for dual-eligible members.	**04/30/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
SB 412 Limón	**Home Care Aides:** Would require a home care organization to ensure that a home care aide completes training related to the special care needs of clients with dementia prior to providing care and annually thereafter. ***Potential CalOptima Health Impact:*** New training requirements for PACE staff.	**07/02/2025** Passed Assembly Appropriations Committee; referred to Assembly floor **06/17/2025** Passed Assembly Human Services Committee **05/08/2025** Passed Senate floor	CalOptima Health: Watch
Providers			
SB 32 Weber Pierson	**Timely Access to Care:** Would require DHCS, DMHC and the California Department of Insurance to consult stakeholders for the development and adoption of geographic accessibility standards of perinatal units to ensure timely access for enrollees by July 1, 2027. ***Potential CalOptima Health Impact:*** Additional timely access standards; increased contracting with perinatal units.	**07/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **06/02/2025** Passed Senate floor	CalOptima Health: Watch LHPC: Oppose
SB 250 Ochoa Bogh	**Medi-Cal Provider Directory — Skilled Nursing Facilities:** Would require an annually updated provider directory issued by a Medi-Cal MCP to include skilled nursing facilities as a searchable provider type. ***Potential CalOptima Health Impact:*** Modifications to CalOptima Health's online provider directory.	**07/02/2025** Passed Assembly Appropriations Committee; referred to Assembly floor **06/24/2025** Passed Assembly Health Committee **05/29/2025** Passed Senate floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 306 Becker	**Prior Authorization Exemption:** No later than January 1, 2028, would eliminate prior authorization for the most frequently approved covered health care services, except in cases of fraudulent provider activity or clinically inappropriate care ***Potential CalOptima Health Impact:*** Implementation of new UM procedures to assess prior authorization approval rates; decreased number of prior authorizations; decreased care coordination for members.	**07/15/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/28/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
SB 504 Laird	**HIV Reporting:** Would authorize a health care provider for a patient with an HIV infection that has already been reported to a local health officer to communicate with a local health officer or the California Department of Public Health (CDPH) to obtain public health recommendations on care and treatment or to refer the patient to services provided by CDPH. ***Potential CalOptima Health Impact:*** Increased coordination of care for HIV-positive members.	**08/20/2025** Passed Assembly Appropriations Committee; referred to Assembly floor **07/16/2025** Passed Assembly Privacy and Consumer Protection Committee **06/24/2025** Passed Assembly Health Committee **05/08/2025** Passed Senate floor	CalOptima Health: Watch
AB 29 Arambula	**Adverse Childhood Experiences (ACEs) Screening Providers:** Would require DHCS to include community-based organizations, local health jurisdictions and doulas as qualified providers for ACEs trauma screenings and require clinical or other appropriate referrals as a condition of Medi-Cal payment for conducting such screenings. ***Potential CalOptima Health Impact:*** Increased access to care for pediatric members with ACEs.	**04/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 50 Bonta	**Over-the-Counter Contraceptives:** Would allow pharmacists to provide over-the-counter hormonal contraceptives without following certain procedures and protocols, such as requiring patients to complete a self-screening tool. As such, these requirements would become limited to prescription-only hormonal contraceptives. ***Potential CalOptima Health Impact:*** Increased member access to hormonal contraceptives.	**06/09/2025** Passed Senate Business, Professions and Economic Development Committee; referred to Senate Appropriations Committee **04/28/2025** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 55 Bonta	**Alternative Birth Centers Licensing:** Would remove the requirement for alternative birth centers to provide comprehensive perinatal services as a condition of CDPH licensing and Medi-Cal reimbursement. ***Potential CalOptima Health Impact:*** Decreased member access to comprehensive perinatal services; reduced operating requirements for alternative birth centers.	**06/11/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **04/28/2025** Passed Assembly floor	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.	**06/25/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/29/2025** Passed Assembly floor	CalOptima Health: Watch
AB 280 Aguiar-Curry	**Provider Directory Accuracy:** Would require health plans to maintain accurate provider directories, starting with minimum 60% accuracy by July 1, 2026, and increasing to 95% by July 1, 2029, or otherwise receive administrative penalties. If a patient relies on inaccurate directory information, would require the provider to be reimbursed at the out-of-network rate without the patient incurring charges beyond in-network cost-sharing amounts. Would also allow DMHC to create a standardized format to collect directory information as well as establish methodologies to ensure accuracy, such as use of a central utility, by January 1, 2026. Additionally, would require a health plan to provide information about in-network providers to enrollees upon request, including whether the provider is accepting new patients at the time, and would limit the cost-sharing amounts an enrollee is required to pay for services from those providers under specified circumstances. ***Potential CalOptima Health Impact:*** Increased oversight of CalOptima Health provider directory; increased coordination with contracted providers; increased penalty payments to DHCS.	**07/09/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/02/2025** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose
AB 375 Nguyen	**Qualified Autism Service Paraprofessional:** Would expand the definition of "health care provider" to also include a qualified autism service paraprofessional. ***Potential CalOptima Health Impact:*** Increased access to autism services for eligible members; additional provider contracting and credentialing.	**04/08/2025** Passed Assembly Business and Professions Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 416 Krell	**Involuntary Commitment:** Would authorize a person to be taken into custody by an emergency physician under the Lanterman-Petris-Short Act and would exempt the emergency physician from criminal and civil liability. ***Potential CalOptima Health Impact:*** New legal standards for certain CalOptima Health providers.	**07/02/2025** Passed Senate Judiciary Committee; referred to Senate Appropriations Committee **05/15/2025** Passed Assembly floor	CalOptima Health: Watch
AB 510 Addis	**Utilization Review Appeals and Grievances:** Would require that an appeal or grievance regarding a decision to delay, deny or modify health services be reviewed by a physician or peer health care professional matching the specialty of the service within two business days. In urgent cases, responses must match the urgency of the patient's condition. If these deadlines are not met, the authorization request would be automatically approved. ***Potential CalOptima Health Impact***: Expedited and modified UM, grievance and appeals procedures for covered Medi-Cal benefits; increased hiring of specialists to review grievances and appeals.	**04/22/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
AB 512 Harabedian	**Prior Authorization Timelines:** Would shorten the timeline for prior or concurrent authorization requests to no more than 24 hours via electronic submission or 48 hours via non-electronic submission for *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.	**07/09/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/03/2025** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
AB 517 Krell	**Wheelchair Prior Authorization:** Would prohibit a Medi-Cal MCP from requiring prior authorization for the repair of a Complex Rehabilitation Technology (CRT)-powered wheelchair, if the cost of repair does not exceed $1,250. Would also no longer require a prescription or documentation of medical necessity, if the wheelchair has already been approved for use by the patient. Additionally, would require supplier documentation of the repair. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**04/08/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 539 Schiavo	**One-Year Prior Authorization Approval:** Would require a prior authorization for a health care service to remain valid for a period of at least one year, or throughout the course of prescribed treatment if less than one year, from the date of approval. ***Potential CalOptima Health Impact:*** Modified UM procedures for covered Medi-Cal benefits; decreased number of prior authorizations; increased costs.	**05/12/2025** Passed Assembly floor; referred to Senate	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
AB 787 Papan	**Provider Directory Disclosures:** Would require a health plan to include in its provider directory a statement advising an enrollee to contact the plan for assistance in finding an in-network provider. Would also require the plan to respond within one business day if contacted for such assistance and to provide a list of in-network providers confirmed to be accepting new patients within two business days for urgent requests and five business days for nonurgent requests. Medi-Cal MCPs would not be required to distribute a printed provider directory. ***Potential CalOptima Health Impact:*** Expanded customer service support and staff training; technical changes to CalOptima Health's provider directory.	**06/18/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/05/2025** Passed Assembly floor	CalOptima Health: Watch
AB 1041 Bennett	**Provider Credentialing:** Would require a health plan to credential a provider within 90 days from the receipt of a completed application, or otherwise conditionally approve the credential. A plan would be required to notify the provider whether the application is complete within 10 days of receipt. Additionally, would require a health plan to use the standardized credentialing form on and after January 1, 2028, or six months after the form is developed, whichever is later. ***Potential CalOptima Health Impact:*** Expedited and modified credentialing procedures for interested providers.	**07/02/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/03/2025** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose Unless Amended

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Rates & Financing			
SB 339 Cabaldon	**Medi-Cal Laboratory Rates:** Would require Medi-Cal reimbursement rates for clinical laboratory or laboratory services to *equal* the lowest of the following metrics: 1. the amount billed; 2. the charge to the general public; 3. 100% of the lowest maximum allowance established by Medicare; or 4. a reimbursement rate based on an average of the lowest amount that other payers and state Medicaid programs are paying. For any such services related to the diagnosis and treatment of sexually transmitted infections on or after July 1, 2027, the Medi-Cal reimbursement rates shall not consider the rates described in clause (4) listed above. ***Potential CalOptima Health Impact*:** Increased payments to contracted clinical laboratories.	**04/29/2025** Passed Senate Judiciary Committee; referred to Senate Appropriations Committee **04/23/2025** Passed Senate Health Committee	CalOptima Health: Watch

Information in this document is subject to change as bills proceed through the legislative process.

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

Last Updated: August 21, 2025

2025 Federal Legislative Dates

January 3	119th Congress, 1st Session convenes
July 25–September 1	Summer recess for House
August 2–September 1	Summer recess for Senate
December 19	1st session adjourns

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

2025 State Legislative Dates

January 6	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
February 21	Last day for legislation to be introduced
April 10–20	Spring recess
May 2	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house
May 9	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house
May 23	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house
June 2–6	Floor session only
June 6	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 18	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 18–August 17	Summer recess
August 29	Last day for fiscal committees to report bills in their second house to the Floor
September 2–12	Floor session only
September 5	Last day to amend bills on the Floor
September 12	Last day for each house to pass bills; interim recess begins upon adjournment
October 12	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2025 Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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About CalOptima Health

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

H.R. 1: One Big Beautiful Bill Act

Fiscal Year 2025 Federal Budget Reconciliation

As signed into law on July 4, 2025

Please note that H.R. 1 includes several distinct implementation dates over the coming years, but there are no major immediate impacts to Medicaid beneficiaries until 2026.

In addition, most Medicaid provisions of H.R. 1 still require federal rulemaking by the U.S. Centers for Medicare and Medicaid Services (CMS) and subsequent state implementation by the California State Legislature and/or the California Department of Health Care Services (DHCS).

MEDICAID HIGHLIGHTS
Eligibility
Work, community service and/or education requirement of **80 hours per month** for able-bodied adults ages 19–64 (with exceptions for short-term hardship, parents with dependents under age 14, pregnant women, medically frail, caregivers and others), effective **December 31, 2026** (or no later than **December 31, 2028**, at the discretion of the U.S. Secretary of Health and Human Services [HHS])
Increased frequency of eligibility redeterminations for Medicaid Expansion (MCE) enrollees from annually to **every six months**, effective **December 31, 2026**
Financing
Prohibition on any new or increased provider taxes, effective **immediately**
Existing provider taxes (except those related to nursing or intermediate care facilities) would be gradually reduced from the current maximum **6.0%** hold harmless threshold to a new **3.5%** hold harmless threshold by **0.5% annually** from **October 1, 2027, through October 1, 2031**
Significant restrictions on current Managed Care Organization (MCO) taxes, which could effectively **repeal** California's MCO tax that was recently made permanent by Proposition 35 (2024), with a potential winddown period of up to **three fiscal years** at the discretion of the HHS Secretary
Cap on new state-directed payments (SDPs) at **100%** of the Medicare payment rate, effective **immediately**; gradually reduces existing SDPs to that cap by **10% annually**, starting **January 1, 2028**
Emergency Medicaid services provided to all undocumented beneficiaries would be subject to the traditional Federal Medical Assistance Percentage (FMAP) — **50%** in California — regardless of the FMAP for which those would otherwise be eligible, effective **October 1, 2026**
Access
Cost-sharing for MCE enrollees with incomes of **100–138%** Federal Poverty Level (FPL), not to exceed **$35** per service and **5.0%** of total income, and not to be applied to primary, prenatal, pediatric, behavioral or emergency care, effective **October 1, 2028**
Temporary **one-year** prohibition on all Medicaid funding to Planned Parenthood, effective **immediately**

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Fiscal Year 2025–26 Enacted State Budget

On May 14, Governor Gavin Newsom released a Fiscal Year (FY) 2025–26 Revised State Budget Proposal, known as the May Revision. On June 13, the State Senate and State Assembly both passed a counterproposal — Senate Bill (SB) 101 — as a placeholder budget to meet the June 15 constitutional deadline while negotiations with the governor on a final budget remained ongoing.

On June 24, Gov. Newsom and legislative leaders announced a final budget agreement. After both houses of the Legislature passed the agreed-upon revisions as Assembly Bill (AB) 102 on June 27, Gov. Newsom signed both SB 101 and AB 102 into law. Additionally, the Legislature passed and the governor signed the consolidated Health Trailer Bill (AB 116) containing policy changes needed to implement health-related budget expenditures. Together, these bills represent the FY 2025-26 Enacted State Budget.

MEDI-CAL HIGHLIGHTS
Unsatisfactory Immigration Status (UIS)-Member Impacts
Freeze on *new* enrollment of UIS individuals ages 19+ (except those who are pregnant or one-year postpartum), effective **January 1, 2026**, including a three-month grace/cure period for re-enrollment following payment of outstanding premium balances; *currently enrolled* individuals are not affected
Implementation of $30/month premiums for UIS individuals ages 19–59, effectively **July 1, 2027**
Elimination of dental coverage for UIS individuals ages 19+, effective **July 1, 2026**
Elimination of Prospective Payment System rates to Federally Qualified Health Centers for state-only-funded services provided to UIS individuals, effective **July 1, 2026**
All-Member Impacts
Reinstatement of asset limit at $130,000 for individuals (plus $65,000 for each additional household member) in non-Modified Adjusted Gross Income eligibility categories, effective **January 1, 2026**
Elimination of pharmacy coverage for GLP-1 agonists for weight loss; coverage for diabetes and on a case-by-case basis will continue, effective **January 1, 2026**
Elimination of pharmacy coverage of some over-the-counter drugs, including COVID-19 antigen tests, vitamins and certain antihistamines, such as dry eye products, effective **January 1, 2026**
Implementation of prior authorization for hospice services, effective **July 1, 2026**
Limitation on capitation payments to Program of All-Inclusive Care for the Elderly (PACE) organizations at the midpoint of the actuarial rate ranges, effective **January 1, 2027**
Elimination of the Workforce and Quality Incentive Program (WQIP) for skilled nursing facilities, effective **December 31, 2025**, with all close-out activities to be completed by January 1, 2027

State agencies, including the California Department of Health Care Services, will begin implementing the policies included in the enacted budget. Staff will continue to monitor these policies and provide updates regarding issues that have a significant CalOptima Health impact. In addition, the Legislature will continue to advance policy bills through the legislative process. Bills with funding allocated in the enacted budget are more likely to be passed and signed into law. The Legislature has until September 12 to pass legislation, and Gov. Newsom has until October 12 to either sign or veto that passed legislation.

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CalOptima Health Community Outreach Summary — August and September 2025

Background

CalOptima Health is committed to serving the community by sharing information with current and potential members and strengthening relationships with community partners. To this end, our team attends community coalitions, collaborative meetings and advisory groups and supports our community partners' public activities. Participation includes providing Medi-Cal educational materials and, if criteria are met, financial support and/or CalOptima Health-branded items.

CalOptima Health's participation in public activities promotes:

- Member interaction/enrollment in a CalOptima Health program
- Community awareness of CalOptima Health
- Partnerships that increase positive visibility and relationships with community organizations

Community Outreach Highlight

In 2016, CalOptima Health's Community Relations department launched Cafecito, a community collaborative designed to engage community stakeholders serving the Latino community, as over 44% of CalOptima Health members identify as Latino/Hispanic. The goal of Cafecito is to build strong relationships and enhance collaboration with local organizations to better serve the unique needs of our Latino membership.

Over the years, we have experienced remarkable success through Cafecito, which served as a platform to share information and updates on CalOptima Health, Medi-Cal and critical initiatives. Additionally, community partners network to share information about their programs and services to increase awareness and collaboration. As a result, many organizations have expanded their programs to support the Latino population, in addition to serving all communities in need by providing culturally relevant resources and outreach activities.

As our local community continues to grow and evolve, CalOptima Health has revisited the purpose of Cafecito and will expand the collaborative to reflect the diversity of our community. In this spirit, we have decided to sunset Cafecito and launch Community Connections to be more inclusive of all the communities we serve by expanding our membership to include community stakeholders serving all ethnic groups.

The new name, "Community Connections," reflects CalOptima Health's ongoing commitment to collaboration and fostering strong partnerships with community stakeholders. Expanding this collaboration will support all CalOptima Health members and the broader Orange County community. It will increase awareness and utilization of programs to support access to health care and other critical programs and services.

We look forward to the official launch of Community Connections in Fall 2025, aligning the collaborative with CalOptima Health's mission to serve our members and community with respect, care, equity and inclusivity.

Summary of Public Activities

As of August 6, CalOptima Health plans to participate in, organize or convene 80 public activities in August and September. There were 44 public activities in August, including 14 virtual community/collaborative meetings, 26 community events, three community-based presentations and one Health Network Forum. In September, there will be 36 public activities, including 15 virtual community/collaborative meetings, 20 community events and one Health Network Forum. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided no endorsements since the last reporting period (i.e., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must meet the requirements of CalOptima Health's Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for Letters of Support and Use of CalOptima Health's Name and Logo. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

For additional information or questions, contact CalOptima Health Community Relations Director Tiffany Kaaiakamanu at 714-222-0637 or tkaaiakamanu@caloptima.org.

CalOptima Health

Attachment to the September 4, 2025, CalOptima Health Outreach Summary

Community events hosted by CalOptima Health and community partners in August and September 2025:

August 2025

August 2, 9 a.m.–1 p.m., Back-to-School Health and Wellness Fair, hosted by CalOptima Health and the City of Westminster

Westminster Civic Center, 8200 Westminster Blvd., Westminster

- At least 80 staff members attended (in person)
- Health/Resource Fair, open to the public

August 2, 9 a.m.–Noon, Newport-Mesa School Kickoff Expo, hosted by Newport-Mesa Unified School District

IKEA, 1475 S. Coast Dr., Costa Mesa

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 3, 10 a.m.–2 p.m., Back 2 School Bash, hosted by the City of Anaheim and Councilmember Carlos Leon

Madison Elementary, 1510 S. Nutwood St., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 3, 10 a.m.–Noon, Back-to-School Event, hosted by Big Brothers Big Sisters of Orange County

Big Brothers Big Sisters Office, 1801 E. Edinger Ave. Ste. 101, Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 5, 11 a.m.–1 p.m., Back-to-School Backpack Distribution and Family Resource Fair, hosted by the Boys and Girls Club of Santa Ana

Boys and Girls Club of Santa Ana, 950 W. Highland St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 5, 5–8 p.m., National Night Out, hosted by the City of Garden Grove Police Department

Public Safety Building, 11301 Acacia Pkwy., Garden Grove

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

August 5, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Colchester/Vancouver Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 6, 3–5 p.m., Back-to-School Resource Fair, hosted by Hope through Housing

Hope through Housing Foundation, Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 7, 10 a.m.–Noon, CalOptima Health Medi-Cal Overview in English

Crime Survivors, Inc., Virtual

- At least one staff member presented
- Community-based organization presentation, open to members/community

August 7, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Rose/Bush/Vine Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 7, 4–6 p.m., Back to School Fair, hosted by Fullerton School District and the County of Orange Social Service Agency

Nicolas Community Center, 1100 W. Olive Ave., Fullerton

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 8, 10–11:30 a.m., CalOptima Health Medi-Cal Overview in English

Orchard View Garden Apartments, 8250 Valley View St., Buena Park

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

August 9, 9 a.m.–12:30 p.m., Back-to-School Resource Fair, hosted by the TGR Learning Lab

TGR Learning Lab, 1 Tiger Woods Way, Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 9, 10:30 a.m.–1:30 p.m., Back-to-School Picnic, hosted by CASA OC

Saddleback Church, 1 Saddleback Pkwy., Lake Forest

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 12, 4–6:30 p.m., Back-to-School Night, hosted by W.R. Nelson Elementary School

W.R. Nelson Elementary School, 14392 Browning Ave., Tustin

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 12, 4–6 p.m., Back-to-School Health Fair, hosted by Capistrano Unified School District and the County of Orange Social Services Agency

San Juan Elementary School, 31642 El Camino Real, San Juan Capistrano

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 14, 3:30–5 p.m., Back-to-School Event, hosted by Hope through Housing Foundation

Oakcrest Terrace, 22744 Eastpark Dr., Yorba Linda

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 15, Noon–4 p.m., Northgate-Gonzales Market Corporate Health and Benefits Fair, hosted by Northgate-Gonzales Markets

Northgate Gonzalez Market Commissary, 2450 White Rd., Irvine

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 15–17, 5–10 p.m., Cultural Heritage Festival, hosted by Orange County Supervisor Janet Nguyen

Freedom Hall at Mile Square Park, 16801 Euclid St., Fountain Valley

- Direct Vendor Payments: $25,000; included two resource booths, 10 VIP tickets, 5 VIP parking passes, private VIP restrooms, VIP lounge, and complimentary food and beverage.
- At least ten staff members attended (in person)
- Health/Resource Fair, open to the public

August 16, 8:30 a.m.–12:30 p.m., Project Hero Back-to-School Event, hosted by Magnolia School District

Pyles Elementary School, 10411 S. Dale Ave., Stanton

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 16, 10 a.m.–2 p.m., Back-to-School Celebration, hosted by Naturally Fit Movement

Naturally Fit Movement, 23591 El Toro Rd., Lake Forest

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 19, TBD, 2025 School-Based Mental Health Summit, hosted by the Orange County Department of Education

Hilton Orange County Costa Mesa, 3050 Bristol St., Costa Mesa

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 19, 11 a.m.–1 p.m., Backpacks for Success, hosted by the City of Placentia

Whitten Community Center, 900 S. Melrose St., Placentia

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 20, 10:30 a.m.–Noon, CalOptima Health Medi-Cal Overview in English

The Cambodian Family Community Center, 1626 E. 4th St., Santa Ana

- At least one staff member presented
- Community-based organization presentation, open to members/community

August 21, 4:30–6:30 p.m., Back-to-School Night, hosted by Martin Elementary School

Martin Elementary School, 939 W. Wilshire Ave., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 21, 5:30–7 p.m., Back-to-School Night, hosted by Garfield Elementary School

Garfield Elementary School, 850 S. Brown St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 22, 5:30–8:30 p.m., Back-to-School Resource Fair, hosted by the City of Santa Ana Parks and Recreation

Garfield Community Center, 501 N. Lacy St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 23, 9 a.m.–Noon, Summer Care Fair: A Back-to-School Resource Event, hosted by Orange County Child Support Services

Orange County Child Support Services, 1055 N. Main St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 23, 5–10 p.m., Layali Little Arabia, hosted by the Arab American Civic Council

Brookhurst Plaza Inn, 711 S. Brookhurst St., Anaheim

- Sponsorship fee: $2,500; included a resource booth, logo/banner placement on the stage backdrop, logo on promotional materials, half-page ad, email and website acknowledgement and social media feature.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

September 2025

September 3, 4:45–6:45 p.m., Back-to-School Night, hosted by Hope School
Hope School, 7901 Knott Ave., Anaheim
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

September 4, 4:45–6 p.m., Back-to-School Night, hosted by Juliette Low School of Arts
Juliette Low School of Arts, 215 N. Ventura St., Anaheim
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

September 4, 4–5:30 p.m., Back-to-School Night, hosted by Willard Intermediate School
Willard Intermediate School, 1342 N. Ross St., Santa Ana
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

September 7, 10 a.m.–Noon, Grandparents Day, hosted by Second Baptist Church
Second Baptist Church, 4300 Westminster Ave., Santa Ana
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

September 12, 5–7 p.m., Open House and Resource Fair, hosted by the Stanton Family Resource Center
Stanton Family Resource Center, 7800 Katella Ave., Stanton
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

September 13, 10 a.m.–1 p.m., 3rd Annual Wings of Hope Mental Health and Resource Fair, hosted by the City of Anaheim
Center Greens Park, 305 E. Broadway, Anaheim
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

September 17, 11 a.m.–2 p.m., 4th Annual Reentry Resource Fair, hosted by the Hub for Integration, Reentry and Employment
Honda Center, 2695 E. Katella Ave., Anaheim
- Sponsorship fee: $1,000; includes a resource booth, organization logo on marketing materials, and social media and community newsletter announcement.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

September 18, 8:30 a.m.–5 p.m., Annual Conference, hosted by Southern California Grantmakers

Westin Bonaventure Hotel and Suites, 404 S. Figueroa St., Los Angeles

- Sponsorship fee: $2,500; includes a resource booth, two conference tickets and organization logo on website.
- At least two staff members to attend (in person)
- Health/Resource Fair, open to the public

September 18, 8:30 a.m.–5 p.m., 2025 Veteran Health and Wellness Conference, hosted by Orange County Veteran and Military Families Collaborative

Irvine Valley College, 5500 Irvine St., Irvine

- Sponsorship fee: $3,800; includes a resource booth, five-minute speaking opportunity in general session, organization branding throughout event and public acknowledgment from podium.
- At least two staff members to attend (in person)
- Health/Resource Fair, open to the public

September 20, 8 a.m.–Noon., Fall 2025 Kids Fishing Derby, hosted by Orange County Supervisor Doug Chaffee

Tri-City Regional Park, 2301 Kraemer Blvd., Placentia

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

September 20, 9 a.m.–Noon, National Diaper Need Awareness Week, hosted by Community Action Partnership of Orange County in partnership with CalOptima Health

Community Action Partnership of Orange County, 11870 Monarch St., Garden Grove

- At least three staff members to attend (in person)
- Health/Resource Fair, open to the public

September 20, 10 a.m.–2 p.m., 3rd Annual Recovery Happens Picnic and Family Fun Day, hosted by Orange County Health Care Agency

Centennial Park, 3000 W. Edinger Ave., Anaheim

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

September 20, 11 a.m.–1 p.m., Active Living Expo, hosted by Huntington Beach Council on Aging

Senior Center in Central Park, 18041 Goldenwest St., Huntington Beach

- Sponsorship fee: $1,500; includes a resource booth, organization name and logo on the website and event materials, a half-page ad, and logo on the save-the-date banner and organization name on the event banner.
- At least two staff members to attend (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

September 24–26, TBD, 23rd Annual Conference, hosted by Vision y Compromiso

Anaheim Marriott, 700 W. Convention Way, Anaheim

- Sponsorship fee: $2,500; includes a resource booth, conference registration for two staff, a program ad and logo placement in conference materials.
- At least two staff members to attend (in person)
- Health/Resource Fair, open to the public

September 25, 8 a.m.–4 p.m., 2025 Thrive Resource Fair, hosted by the Orange County Department of Education

OCDE Kalmus Event Center, 200 Kalmus Dr., Costa Mesa

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

September 27, 8–11 a.m., Community Bike Ride to Raise Cancer Awareness, hosted by Orange County Supervisor Doug Chaffee

California State University Fullerton, 800 N. State College Blvd., Fullerton

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

September 27–28, 11 a.m.–6 p.m., 4th Annual Fall Festival, hosted by the City of Westminster

Westminster Civic Center, 8200 Westminster Blvd., Westminster

- Sponsorship fee: $10,000; includes two resource booths, logo on city webpage, festival flyers social media posts, screen and Fall Festival t-shirts. Additionally, a full-page program ad, recognition in newsletters and verbal recognition at event. Lastly, a five-minute speaking opportunity and complimentary 2026 Tet parade entry.
- At least four staff members to attend (in person)
- Health/Resource Fair, open to the public

September 27, 9–11:30 a.m., Walk/Run to End Child Marriage and Human Trafficking, hosted by Global Hope 365

Green Meadow Park, 5701 Trabuco Rd., Irvine

- Sponsorship fee: $1,000; includes organization name at the event, social media campaign posts and five event tickets.
- At least five staff members to attend (in person)
- Health/Resource Fair, open to the public

September 27, Noon–5 p.m., OC Pride 2025, hosted by OC Pride

OC Fair and Event Center, 88 Fair Dr., Costa Mesa

- Registration fee: $515; includes a resource booth.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

September 27, 1–4 p.m., Embracing Aging Expo, hosted by the City of Westminster

Westminster Senior Center, 8200 Westminster Blvd., Westminster

- Sponsorship fee: $650; includes double booth space, organization listed in event program and website, announcement of sponsorship at event, half a page ad in event program, banner displayed at the senior center and an opportunity for a presentation at a later date.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

These sponsorship request(s) and community event(s) met the requirements of CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at:
https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

Board-Approved Strategic Initiatives Executive Summary – Report Period: April 2025 – June 2025

CalOptima Health's Board of Directors has authorized $1,236.7 million in funding and investment in programs and strategic initiatives to improve community and member health and wellness. Detailed impact summary reports are attached.

Exhibit 1: Board Approved Initiatives (as of June 30, 2025)

Board-approved Initiatives	INITIATIVE LEADER	Program Status	Payment Status	Board Approved Amount	Spent Amount	Additional Amounts Committed	Amounts Committed[1]	Resource Available[2]	Duration
Community Outreach and Investments									
Adult Expansion Outreach Strategy	Thompson	In progress	Complete	$ 7.6	$ 4.3	$ 2.5	$ 6.8	$ 0.8	01/01/2024 - 06/30/2025
CalFresh and Redetermination Outreach	Thompson	In progress	In Progress	$ 6.0	$ 4.3	$ (0.1)	$ 4.2	$ 1.8	04/04/2024 - 06/30/2025
CalFresh Outreach Strategy	Thompson	Complete	Complete	$ 2.0	$ 2.0	$ (0.0)	$ 2.0	$ 0.0	04/01/2022 - 12/31/2022
CalOptima Health Community Reinvestment Program	Rose	In progress	Not yet started	$ 38.0	$ -	$ -	$ -	$ 38.0	CY 2024
Coalition of OC Community Health Centers	Bruno-Nelson	In progress	In Progress	$ 50.0	$ 24.3	$ 25.7	$ 50.0	$ -	FY 2023 - FY 2027
Garden Grove Recovery Center Development and Maintenance	Bruno-Nelson	In progress	In Progress	$ 10.5	$ 0.7	$ 0.4	$ 1.1	$ 9.4	TBD
General Awareness and Brand Development	Thompson	In progress	In Progress	$ 4.7	$ 4.3	$ 0.0	$ 4.3	$ 0.4	Ongoing
Homeless Health Initiative	Bruno-Nelson	In progress	In Progress	$ 65.9	$ 45.1	$ 19.2	$ 64.3	$ 1.6	Multiple
Housing and Homelessness Incentive Program	Bruno-Nelson	In progress	In Progress	$ 87.4	$ 61.5	$ 11.4	$ 72.9	$ 14.5	Multiple
In-Home Care Pilot Program with the UCI Family Health Center	Dabbah	In progress	Not yet started	$ 2.0	$ -	$ -	$ -	$ 2.0	09/01/2023 - 08/31/2025
Member and Population Health Needs Assessment	Laverdiere	In progress	In Progress	$ 1.3	$ 0.7	$ 0.5	$ 1.2	$ 0.1	02/2023 - 03/2026
Mind OC Grant (Irvine)	Bruno-Nelson	In progress	Complete	$ 15.0	$ 15.0	$ -	$ 15.0	$ -	12/01/2022 - 12/31/2025
Naloxone Distribution Event	Carpenter	Complete	Complete	$ 15.0	$ 12.8	$ 0.2	$ 13.0	$ 2.0	FY 2024
NAMI Orange County Peer Support Program	Katsarov	In progress	In Progress	$ 5.0	$ 2.0	$ 3.0	$ 5.0	$ -	CY 2023 - CY 2027
OneCare Outreach and Engagement Strategy	Thompson	In progress	In Progress	$ 1.2	$ 0.9	$ 0.0	$ 1.0	$ 0.2	04/01/2024 - 06/30/2024
Provider Workforce Development	Laverdiere	In progress	In Progress	$ 50.0	$ 5.5	$ 24.3	$ 29.7	$ 20.3	FY 2024 - FY 2028
Stipend Program for Masters of Social Work	Bruno-Nelson	In progress	Complete	$ 5.0	$ 5.0	$ -	$ 5.0	$ -	FY 2024 - FY 2028
Wellness Prevention Program	Katsarov	In progress	In Progress	$ 2.7	$ 1.2	$ 1.5	$ 2.7	$ -	FY 2024 - FY 2027
Homeless Prevention and Stabilization Pilot Program	Hunn	In progress	Not yet started	$ 0.3	$ 0.0	$ 0.2	$ 0.3	$ -	01/01/2025 - 06/30/2027
OneCare Member Engagement and Education - Star Rating	Sanchez	In progress	Not yet started	$ 0.3	$ -	$ -	$ -	$ -	04/01/2025 - 03/31/2026
Subtotal				*$ 369.8*	*$ 189.7*	*$ 88.8*	*$ 278.5*	*$ 91.0*	
Quality Incentive Programs									
Comprehensive Community Cancer Screening*	Pitts	In progress	In Progress	$ 50.1	$ 6.1	$ 15.9	$ 22.0	$ 28.0	CY 2023 - CY 2027
Dyadic Services Program Academy	Katsarov	In progress	In Progress	$ 1.9	$ 0.9	$ 1.0	$ 1.9	$ 0.0	04/30/2024 - 03/31/2026
Five-Year Hospital Quality Program	Lee	In progress	In Progress	$ 153.5	$ 33.2	$ 120.3	$ 153.5	$ -	CY 2023 - CY 2027
Quality Initiatives from Unearned P4V Program MY2023	Lee	In progress	In Progress	$ 23.3	$ 4.5	$ 11.4	$ 16.0	$ 7.3	FY 2024 - FY 2025
Subtotal				*$ 228.7*	*$ 44.7*	*$ 148.7*	*$ 193.4*	*$ 35.3*	
Infrastructure and Capacity Building									
Digital Transformation Strategy (DTS)[3]	Kim	In progress	In Progress	$ 100.0	$ 70.8	$ 19.4	$ 90.2	$ 9.8	FY 2023 - FY 2027
IGT Administrative Withhold (staff to support IGT Program)*	Laverdiere	In progress	In Progress	$ 2.0	$ 0.8	$ 1.2	$ 2.0	$ -	01/01/2021 - TBD
Medi-Cal Provider Rate Increases	Kim	In progress	In progress	$ 526.2	$ 210.5	$ 315.7	$ 526.2	$ -	07/01/2024 - 12/31/2026
Skilled Nursing Facility Access Program	Dabbah	In progress	Not yet started	$ 10.0	$ -	$ -	$ -	$ 10.0	FY 2024 - FY 2026
Subtotal				*$ 638.2*	*$ 282.1*	*$ 336.3*	*$ 618.4*	*$ 19.8*	
Total				**$ 1,236.7**	**$ 516.5**	**$ 573.8**	**$ 1,090.3**	**$ 146.1**	

[1] Amounts Committed include payments and remaining balance of open Purchase Orders and/or an estimation of amounts committed
[2] Resource Available is the amount available for new initiatives after deduction of the Amount Commited from the Board Approved Amount
[3] Amounts Committed for DTS are preliminary estimates
[4] Past Supplemental Funding
[5] Amounts Committed for the Hospital Quality Program is based on 100% earnable payout. The actual payout amount is determined based on hospital quality performance.
* Initiatives funded by IGT dollars

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	8/6/2025	**Initiative Name:**	Adult Expansion Outreach Strategy	**Start Date:**	7/1/2024
Reporting Period:	Apr-Jun (Q4)			**End Date:**	6/30/2025
Program Status:	Complete	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$7.6 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health implemented the Adult Expansion Outreach Strategy to promote awareness and enrollment of eligible adults ages 26-49 into full-scope Medi-Cal, regardless of immigration status, and enrollment in other public assistance programs (i.e., CalFresh).	-Program is complete; funds are fully spent for project needs. - Adult Expansion: Total Spent: $3,711,315 ($1,342,000 Comms; $2,369,315 CR); Total Remaining: $3,210,685 (includes 2nd payment to Community Enrollers). - Multimedia advertising campaign: Spent: $1,342,000; Remaining: $0 - Community Enrollers: Spent $2,016,815; Remaining: $2,563,185 (Half has been paid, pending 2nd payment of $2,286,743 in the coming months; AltaMed withdrew leaving an additional $499,999). - MC Expansion Sponsorship: Spent: $352,500; Remaining: $147,500 [$500,000 mobile unit (project on hold)]. - $0.8m in unspent funds to be reallocated; payment status is complete.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop a multimedia campaign in Spanish	Number of impressions/media buys	Impressions by media type for Q4: Digital advertising: 2,420,732 Traditional advertising: 102,404,791 No additional spending is planned.
Conduct community outreach and enrollment events	Number of events hosted	38 community events focused on Medi-Cal expansion have been sponsored totaling $365,000 in funding. These events included Community Enrollers for Medi-Cal enrollment/redetermination and CalFresh enrollment, a legal non-profit organization and CalOptima Health.
Increase awareness and enrollment in the Medi-Cal and CalFresh programs, with a focus on outreach to the undocumented population	Number of Community Enrollers	12 organizations were funded to have Community Enrollers for Medi-Cal enrollment/renewals and CalFresh enrollment. We are currently halfway through the funding period. In June 2025, one organization terminated services. 11 organizations are currently continuing services.
Create a communications toolkit to promote Medi-Cal expansion	Completion of communications toolkit	Toolkit materials were posted online at www.caloptima.org/CoverageForAll; materials will be removed since there are federal/state changes planned.
CalOptima Health Mobile Unit	Mobile unit purchased by end of 2024	Project is on hold.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	8/15/2025	**Initiative Name:**	CalFresh and Redetermination Outreach	**Start Date:**	2/2/2023
Reporting Period:	Apr-Jun (Q4)			**End Date:**	Ongoing
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$6.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health Outreach Strategy to support Medi-Cal redetermination and enroll potentially eligible CalOptima Health members in the CalFresh program.	Currently being evaluated for potential reallocation of any identified unspent funds.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop a comprehensive marketing and advertising campaign to promote Medi-Cal redetermination.	Campaign development Number of impressions/media buys	Total Impressions for Q4: Digital: 16,400,172 Traditional: 4,184,128
Collaborate w/ key stakeholders by hosting community events focused on Medi-Cal redetermination and the CalFresh program throughout the county.	Number of community events Number of members served	38 community events focused on Medi-Cal expansion have been sponsored totaling $365,000 funding. These events included Community Enrollers for Medi-Cal enrollment/redetermination and CalFresh enrollment, a legal non-profit organization and CalOptima Health.
Fund Community Enrollers to support members with Medi-Cal renewals and enrollment in CalFresh.	Number of Community Enrollers	12 organizations were funded to have Community Enrollers for Medi-Cal enrollment/renewals and CalFresh enrollment. We are currently halfway through the funding period. In June 2025, one organization terminated services. 11 organizations are currently funded.
Community Enrollers to ensure as many members enroll/retain Medi-Cal coverage throughout the resumption of redetermination.	Number of completed membership enrollment and renewal applications	To date, Community Enrollers have completed 5,022 Medi-Cal applications and 1,802 Medi-Cal renewals.
Community Enrollers to engage members in the communty to provide Medi-Cal renewal assistance and CalFresh enrollment service	Number of community events	Community Enrollers attended 700 additional community events to support Medi-Cal expansion/redetermination and CalFresh.

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CalOptima Health

Community Investment Status Report
Initiative: Community Enrollers

Partner Organization	NOFO Round	Program Title	Program Dates	Program Metrics	Grant Amount	Payments To Date	Grant Status
Abrazar, Inc.	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 200,000	$ 100,000	In Progress
Camino Health Center	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 250,000	$ 125,000	In Progress
Community Action Partnership of OC (CAPOC)	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 365,000	$ 182,500	In Progress
Give for a Smile	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 233,628	$ 116,814	In Progress
Orange County United Way	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 354,408	$ 177,204	In Progress
Serve the People Community Health Center	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 383,020	$ 191,510	In Progress
Vista Community Clinic	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	10/1/25 - 9/30/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 207,430	$ 103,715	In Progress
Community Health Initiative of OC (CHIOC)	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	11/1/25 - 10/31/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 500,000	$ 250,000	In Progress
Friends of Family Health Center	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	11/1/25 - 10/31/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 230.246	$ 115,123	In Progress
Latino Health Access	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	11/1/25 - 10/31/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 500.000	$ 250,000	In Progress
Mental Health Association of Orange County	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	11/1/25 - 10/31/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 349.593	$ 174,796.50	In Progress
Southland Integrated Services, Inc.	1	Medi-Cal renewal/enrollment and CalFresh enrollment services	11/1/25 - 10/31/26	60 Medi-Cal apps & 20 renewals, & 10 CalFresh apps per Enroller per month	$ 500.000	$ 250,000	In Progress
					$	$	
					$	$	
					$	$	
					$	$	

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	8/6/2025	**Initiative Name:**	CalFresh Outreach Strategy	**Start Date:**	3/3/2022
Reporting Period:	Apr-Jun (Q4)			**End Date:**	Ongoing
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$2.0 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalFresh Outreach Strategy is designed to enroll potentially eligible CalOptima Health members in the CalFresh program to promote food security.	Community Relations and Communications has fully spent funds.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop a comprehensive marketing and advertising campaign to promote enrollment in CalFresh.	Campaign development Number of impressions/media buys	Advertising ads concluded in January 2025. No impressions to report for Q4.
Collaborate w/ key stakeholders by hosting community events focused on the CalFresh program throughout the county.	Number of community events Number of members served	This calendar year, CalOptima Health hosted 4 large scale events that included CalFresh enrollment assistance with the support of Social Services Agency and funded Community Enrollers. At these events, approximately 4,900 members and community members were served.
Produce direct mail promoting the availability of CalFresh benefits.	Number of mailers sent	Communications determined that mailers were not strategically feasible based on feedback from SSA and CalFresh changes. No mailers will be sent.
Increase enrollment in CalFresh program.	Number of members supported by CalFresh	SSA reports a 34% growth in CalFresh enrollment from January 2021 thru May 2024, as compared to statewide enrollment growth of 30.8%. To date, funded Community Enrollers have submitted 2,137 CalFresh applications.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	08/14/2025	**Initiative Name:**	CalOptima Health Community Reinvestment (CR) Program	**Start Date:**	11/1/2023
Reporting Period:	Apr-Jun (Q4)			**End Date:**	2024
Program Status:	In Progress	**Initiative Owner:**	Dr. Michaell Rose	**Approved Amount:**	$38.0 Million
Payment Status:	Not Started				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
As part of the Comprehensive Quality Strategy and Population Health Management Policy Guide, DHCS is requiring all MCPs to reinvest a portion of their net income into community-driven solutions that address social drivers of health and reduce health disparities as follows: - 5% of the portion of annual net income that is less than or equal to 7.5% of revenue for the year; and - 7.5% of the portion of annual net income that is greater than 7.5% of revenue for the year.	- Launched both internal and external workgroups for Community Reinvestment. - Conducted a review of CY 2024-2025 voluntary investments to ensure they align with and meet the financial obligations for CY 2024. Findings were shared with the internal and external Community Reinvestment Workgroups. - On track to develop and submit CalOptima Health's initial Community Reinvestment Plan to DHCS in Q3 CY 2026. - No new investments planned from the current allocation.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Establish Community Reinvestment Program internal and external stakeholder workgroups	Establish internal stakeholder workgroup by Q1 2025 and external stakeholder workgroup by Q3 2025.	Community Reinvestment Internal Workgroup launched March 12, 2025. Community Reinvestment Joint Internal and External Workgroup launched June 3, 2025 and will convene quarterly.
Develop Community Reinvestment Program activities and workplan	Community Reinvestment Program Workplan developed by Q2 2025.	Finalizing the Community Reinvestment Program Workplan. Initial Community Reinvestment plan submission is due to DHCS in Q3 CY 2026.
Obtain stakeholder input on Community Reinvestment through engagement with Member/Provider Advisory Committees	Stakeholder committees convened for community input on investments	Distributed a survey at the April 10, 2025 MAC/PAC meeting to gather feedback on Community Reinvestments. Conducted follow-up engagement to obtain more insights and ensure community perspectives are integrated into ongoing efforts.
Allocate required portion of net income in improving the health and wellbeing of members through locally driven innovations and whole-person approach	% of annual net income reinvested in local communities	Not yet started
	Number of community reinvestment programs implemented	Not yet started

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	8/18/2025	**Initiative Name:**	Coalition of OC Community Health Centers	**Start Date:**	6/1/2022
Reporting Period:	Apr-Jun (Q4)			**End Date:**	6/30/2027
Program Status:	In Progress	**Initiative Owner:**	Kelly Bruno-Nelson	**Approved Amount:**	$50.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Coalition's five-year, $50 million initiative with participating subgrantee community health centers to enhance access, quality, and further strengthen the safety net system across Orange County. The initiative focuses on building capabilities of participating clinics related to data and quality improvement, care delivery, and transitioning towards value-based care.	- As of June 30, 2025 the Coalition has completed the third year of this initiative. There are 27 clinics participating in the program. - A grant agreement amendment was executed that did not change the SOW or total amount of the grant, but did require the submission and approval by CalOptima Health of an annual budget and workplan prior to commencing year four or five work.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Provide monitoring, guidance, and support to subgrantee implementation projects from Year 1 to Year 3.	% of planned milestones that have been successfully achieved within the specified timeframe	100% of milestones for year three have been achieved. The partners have established systems to regularly monitor and evaluate health center progress. Participating health centers submit status reports to the consultants on a quarterly basis.
Provide timely technical assistance and support to subgrantees over 5 year grant period.	Number of training workshops, webinars, and sessions conducted	100% complete for year three. IHQC provided semi-annual convenings, populations of focus workshops and webinars, peer groups (bi-monthly starting in 2025) and 1:1 coaching. A total of 16 trainings and at least 6 additional workshops and webinars were provided in year three.
Ensure data collection and reporting compliance over 5 year grant period.	Timely submission of reports by health centers with feedback from technical assistance staff	100% for year three. Standardized quarterly project status reports and project dashboards include tailored feedback loop from IHQC Team.
Build the capacity of Coalition to support health centers in practice transformation and quality improvement from Years 2 to 5.	-Positions outlined in the budget hired -% of Coalition staff completed technical assistance trainings	60% complete and still in progress. There are still a few positions that have yet to be filled. Current staff are actively participating in training programs led by IHQC. Staff also completed the Patient Centered Medical Home training.
Support health center staff in development of value-based quality improvement and data strategic plans.	Creation of health center VBC strategic plans	50% complete and still in progress. Developmental work has been conducted with several health centers and has revealed a need for clearer QI frameworks. These learnings will be accounted for as plans for each health center are developed in the coming program years.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	8/19/2025	**Initiative Name:**	Garden Grove Recovery Center Development and Maintenance	**Start Date:**	9/1/2023
Reporting Period:	Apr-Jun (Q4)			**End Date:**	TBD
Program Status:	In Progress	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$10.5 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Street Medicine Support Center is a service-enriched supportive housing facility focused on providing individuals enrolled in the Garden Grove Street Medicine Program with continued medical wraparound services, housing navigation, and Enhanced Care Management. These services will assist in retaining housing, improving health status, and maximizing the ability to live and (if applicable) work in the community. There will be 50 furnished, private rooms and an outdoor space for socialization and overall mental wellness.	- Held meeting with the City of Garden Grove to discuss timeline for plan submittal. - Design development phase complete June 2025 with construction documents submitted to the City of Garden Grove planning department by July 2025.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Secure architectural firm and complete design and plan approval process	Firm contracted and plans approved by City of Garden Grove	Architect contracted. Construction documents scheduled for submission to the City of Garden Grove in July 2025.
Complete construction	Certificate of Occupancy secured date	Once the construction documents are submitted and approved, start the process of identifying a general contractor and create a construction timeline including a completion date.
Secure a provider	Contract with provider successfully executed	Process of securing a provider to begin once the construction timeline is developed.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	8/15/2025	**Initiative Name:**	General Awareness and Brand Development	**Start Date:**	4/1/2023
Reporting Period:	Apr-Jun (Q4)			**End Date:**	6/30/2026
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$4.7 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
To create and implement a General Awareness and Brand Development campaign that will support enhanced recognition of CalOptima Health's key role in the community, improve understanding of our values and vision, and better reach our members.	The launch of all new assets was completed in Q2 of FY25, including print, digital, outdoor and TV formats. New executions were completed during this reporting period, including advertisements at gas pump locations and the Orange County Fair.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Brand platform development and consulting	Research, strategy, brand messaging and design platforms, brand concept and guidelines	- In FY25, $30,000 was spent in professional fees for monthly reporting.
Campaign creation and execution	Media plan, campaign development and campaign production	- Original campaign assets/ads were completed in FY23. - Refreshed campaign creatives were developed Jul-Sep 2024 for print and digital media ads (TV/video, digital banner and social media ads) in partnership with Maricich Health.
Campaign media buys	Media placements, monitoring and reporting	- Original media plan was developed in FY23 and executed in FY23 (Q4) and FY24. - Additional funds were granted for use in FY25 and FY26. - Media spend for FY25 was $875,714.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	8/18/2025	**Initiative Name:**	Homeless Health Initiative	**Start Date:**	2019
Reporting Period:	Apr-Jun (Q4)			**End Date:**	TBD
Program Status:	In Progress	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$61.7 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Homeless Health Initiative (HHI) began in 2019 when the Board of Directors established a fund to support programs that improved the health of members experiencing homelessness. This fund has supported many projects and programs and continues to support the Homeless Clinic Access Program (HCAP), Outreach and Engagement, and Street Medicine project. Overall, it is helping to increase access to medical services for our members.	- The Street Medicine program is currently operational in three cities: Garden Grove, Costa Mesa and Anaheim. The team sought board approval to expand the program to one new city in 2025 and Santa Ana was selected. An RFP was released for the service provider for the Santa Ana program and that selection will occur in Q3 of 2025. - HCAP continues to operate at 9 shelter sites through the partnership of five local community clinics and homeless shelter operators. It is currently being evaluated for potential reallocation of any identified unspent funds.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop two new programs and/or services to meet the unique needs of our members experiencing homelessness.	Program implementation	Street Medicine and HCAP continue to be offered to the Orange County CalOptima Health membership experiencing homelessness.
Provide 200 participants with point of care service through each of the Garden Grove, Anaheim and Costa Mesa Street Medicine programs.	Number of members served	A total of 796 people were served between the three teams.
Connect 90% of members served through the Garden Grove Street Medicine program to enhanced care management and community supports.	Percent of members connected	A total of 95% were connected to ECM and community supports.
Connect 80% of members served through the Garden Grove Street Medicine program to a primary care physician (PCP).	Percent of members connected	A total of 89% were connected to a PCP.
Connect 25% of members served through the Garden Grove Street Medicine program to housing.	Percent of members connected	A total of 13% have been connected to housing.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:		**Initiative Name:**	Homeless Health Initiative	**Start Date:**	2019
Reporting Period:	Jan-Mar (Q3)			**End Date:**	TBD
Program Status:	In Progress	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$61.7 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Homeless Health Initiative (HHI) began in 2019 when the Board of Directors established a fund to support programs that improved the health of members experiencing homelessness. This fund has supported many projects and programs and continues to support the Homeless Clinic Access Program (HCAP), Outreach and Engagement, and Street Medicine project. Overall, it is helping to increase access to medical services for our members.	- The Street Medicine program is currently operational in three cities: Garden Grove, Costa Mesa and Anaheim. The team sought board approval to expand the program to one new city in 2025 and Santa Ana was selected. An RFP was released for the service provider for the Santa Ana program and that selection will occur in Q3 of 2025. - HCAP continues to operate at 9 shelter sites through the partnership of five local community clinics and homeless shelter operators. It is currently being evaluated for potential reallocation of any identified unspent funds.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Increase access to primary and preventative care services for members experiencing homelessness.	Number of HCAP visits conducted across the nine program sites.	In Q2 of 2025, 1,926 visits were conducted with members across the nine HCAP sites.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	08/18/20	**Initiative Name:**	Housing and Homelessness Incentive Program	**Start Date:**	04/01/2025
Reporting Period:	Apr-Jun (Q4)			**End Date:**	TBD
Program Status:	In Progress	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$87.4 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
HHIP is a voluntary program that aimed to improve health outcomes and access to whole person care services by addressing housing insecurity and instability for the Medi-Cal population. Through this program, CalOptima Health earned $72.9 million of the $83 million for which it was eligible. These funds have been and will continue to be invested into the community to improve the experience of members at-risk for and experiencing homelessness.	- Staff continue to steward 54 active grant projects/agreements that are geared toward improving service to our members experiencing homelessness, including those that increase provider service capacity, support the development of housing projects, and seek to influence systems change. - HHIP Notice of Funding Opportunity Round 4 was released in January 2025 and applications were due in March. Funding was available for systems change and for equity grants to organizations working to resolve social issues for members at risk for homelessness. A total of 27 eligible applications were received across the two funding priorities. Staff brought funding recommendations to the board in June 2025, and two systems change and four equity grants were awarded.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Address housing insecurity and instability among Medi-Cal members.	Earn $83.7M in incentives	Earned $73M of the total incentive.
	Percentage increase / increased number of housed members among unhoused members	Increased percentage and number of unhoused members housed from 1.3% in June 2022 to 34.3% as of October 2023, representing 3,585 members. We are improving the internal algorithm used to calculate this so that we can generate new statistics on the impact of these investments.
	Percentage of members that stayed stably housed	Of members experiencing homelessness in early 2023 that were connected to housing, 69% remained housed through April 2024 (the next measurement period).
Expend all funds contributed to this effort.	Number of grant awards	130 grant awards have been made and are in various stages of implementation.

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CalOptima Health

Housing and Homeless Incentive Program Capital Investments: Status Report

Partner Organization (this column repeats on the next page)	HHIP NOFO Round	Address	SPA	Contract Execution Date	Contract End Date	Total Contract/ Agreement Amount
City of Anaheim - Housing and Community Development Department	2	9150 E. Orangewood Ave. Anaheim, CA 92802	North	12/1/2023	12/1/2024	$1,500,000.00
Community Action Partnership OC	1	10821, 10786, 10782, 10881 Garza Ave. (Senior Duplex units A and B), Anaheim, CA 92802 9301 Katella Ave. (Duplex units A and B), Anaheim, CA 92804	North	4/1/2023	3/31/2024	$98,340.00
The Salvation Army Orange County	1	1401 S. Salvation Pl., Anaheim, CA 92805	North	6/1/2023	3/31/2024	$4,100,000.00
Jamboree Housing Corporation	2	1108 N. Harbor Blvd., Santa Ana, CA 92703	Central	12/1/2023	12/1/2024	$4,721,241.00
National Community Renaissance of California	2	1314 N. Angelina Dr., Placentia, CA 92870	North	12/1/2023	12/1/2024	$1,334,677.00
WISEPlace	2	23240 Orange Ave. #4, Lake Forest, CA 92630	South	12/1/2023	11/30/2025	$1,000,000.00
Pathways of Hope OC	1	504/506 W. Amerige Ave., Fullerton, CA 92832	North	4/1/2023	3/30/2025	$1,500,000.00
Mercy Housing California	2	480 S. Batavia St., Orange, CA 92868	North	12/1/2023	12/1/2025	$1,500,000.00
Golden State Recuperative Care	3	150 Cecil Place, Costa Mesa, CA 92627	Central	6/1/2024	5/31/2034	$3,500,000.00
Mind OC/Be Well OC	3	7800 Marine Way, Irvine, CA 92618	South	6/1/2024	-	$5,000,000.00
Shelter Providers of Orange County, Inc., DBA HomeAid Orange County	2	617, 625, 637 W. La Veta Ave., Orange, CA 92686	North	12/1/2023	12/31/2025	$1,400,000.00
Illumination Foundation	2	918 N. Bewley St., Santa Ana, CA 92703	Central	12/1/2023	11/30/2025	$3,000,000.00
Community Development Partners	2	2274 Newport Blvd., Costa Mesa, CA 92627	Central	1/1/2024	12/31/2025	$8,000,000.00
Kingdom Causes dba City Net	2	2715 E. La Veta Ave., Orange, CA 92869	North	12/1/2023	6/30/2026	$1,337,170.49
Friendship Shelter	1	2435 S. El Camino Real, San Clemente, CA 92672	South	4/1/2023	9/30/2025	$3,850,000.00
Anaheim Housing Authority	2	1251 N. Harbor Blvd., Anaheim, CA 92801	North	12/1/2023	12/1/2025	$3,878,420.00
City of Yorba Linda	2	5086 Avocado Circle, Yorba Linda, CA 92886	North	12/1/2023	12/1/2024	$3,100,000.00
Families Forward	2	1852 San Juan St., Tustin, CA 92780	Central	12/1/2023	12/1/2025	$2,500,000.00
American Family Housing	1	15081 Jackson St., Midway City, CA 92655 1400 Bristol St., Costa Mesa, CA 92626	Central	6/1/2023	3/31/2028	$2,951,660.00
The Eli Home, Inc.	2	3175 W. Ball Road, Anaheim, CA 92804	North	12/1/2023	12/1/2026	$5,000,000.00
City of Anaheim/Anaheim Housing Authority	1	120 S. State College Blvd., Anaheim, CA 92806	North	5/1/2023	4/30/2026	$2,000,000.00
Korean Community Services dba KCS Health Center	1	13091 Galway St., Garden Grove, CA 92844	Central	4/1/2023	3/31/2026	$2,500,000.00
Hart Community Homes	3	220 N. Lemon St., Fullerton, CA 92832	North	6/1/2024	5/31/2034	$4,000,000.00
Illumination Foundation	3	3708 W. Washington St., Santa Ana, CA 92703	Central	6/1/2024	5/31/2034	$3,500,000.00
Casa Youth Shelter	3	10935 Reagan St., Los Alamitos, CA 90720	North	8/1/2024	7/31/2034	$4,000,000.00
Orange County Housing Finance Trust	1	N/A as these ADUs will be cross-county	ALL	5/1/2023	-	$4,000,000.00
C&C Development	2	7101 Lincoln Ave., Buena Park, CA 90620	North	1/1/2024	12/1/2026	$8,000,000.00
City of Brea	2	323 N. Brea Blvd., Brea, CA 92821	North	12/1/2023	12/1/2027	$6,028,491.51

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CalOptima Health

Housing and Homeless Incentive Program Capital Investments: Status Report

Partner Organization	Projected Completion Date	Number of Units Proposed	Number of Units Completed	Previous Site Visit Dates	Next Site Visit Dates	Total Payments To Date	Total Payments Remaining	Grant Open or Closed
City of Anaheim - Housing and Community Development Department	12/30/2023	102	102	10/22/2024	N/A	$1,500,000	$0	Closed
Community Action Partnership OC	3/31/2024	5	5	3/31/2024	N/A	$98,340	$0	Closed
The Salvation Army Orange County	3/31/2024	72	72	6/22/2023	N/A	$4,100,000	$0	Closed
Jamboree Housing Corporation	3/31/2024	91	91	11/20/2024	N/A	$4,721,241	$0	Closed
National Community Renaissance of California	7/30/2024	65	65	5/13/2024	N/A	$1,334,667	$0	Closed
WISEPlace	11/30/2025	5		3/19/2025	9/1/2025	$1,000,000	$0	Open
Pathways of Hope OC	12/31/2024	14	14	9/25/2024	N/A	$1,500,000	$0	Closed
Mercy Housing California	1/30/2025	50	50	12/9/2024	N/A	$1,500,000	$0	Closed
Golden State Recuperative Care	3/31/2026	30		5/8/2025	11/1/2025	$2,000,000	$1,500,000	Open
Mind OC/Be Well OC	-	-	-	-	-	$0	$0	Cancelled
Shelter Providers of Orange County, Inc., DBA HomeAid Orange County	12/31/2025	6		5/6/2025	7/16/2025	$1,400,000	$0	Open
Illumination Foundation	11/30/2025	11		11/7/2024	8/30/2025	$3,000,000	$	Open
Community Development Partners	12/31/2025	87		5/8/2025	11/1/2025	$8,000,000	$0	Open
Kingdom Causes dba City Net	6/30/2026	20		4/21/2025	10/15/2025	$1,337,170	$0	Open
Friendship Shelter	9/30/2025	11		3/19/2025	7/31/2025	$3,850,000	$0	Open
Anaheim Housing Authority	9/30/2025	89		5/13/2025	11/15/2025	$3,878,420	$0	Open
City of Yorba Linda	9/30/2025	66	67	11/13/2024	N/A	$3,100,000	$0	Closed
Families Forward	11/1/2025	8		5/19/2025	12/1/2025	$2,500,000	$0	Open
American Family Housing	3/31/2028	111		10/31/2024	8/30/2025	$2,951,660	$0	Open
The Eli Home, Inc.	2/1/2026	11		6/25/2025	12/30/2025	$5,000,000	$0	Open
City of Anaheim/Anaheim Housing Authority	3/31/2026	32		5/13/2025	11/15/2025	$2,000,000	$0	Open
Korean Community Services dba KCS Health Center	3/31/2026	100		5/6/2025	11/1/2025	$2,500,000	$0	Open
Hart Community Homes	5/30/2026	20		5/8/2025	11/1/2025	$0	$4,000,000	Open
Illumination Foundation	5/30/2026	30		3/26/2025	8/30/2025	$1,895,575	$1,604,425	Open
Casa Youth Shelter	7/31/2026	14		3/6/2025	10/1/2025	$0	$4,000,000	Open
Orange County Housing Finance Trust	-	-	-	11/30/2023	N/A	$0	$0	Cancelled
C&C Development	1/30/2027	55		4/22/2025	10/15/2025	$8,000,000	$0	Open
City of Brea	5/31/2027	40	40	5/29/2025	11/15/2025	$6,028,492	$0	Open
		1215	463					

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Board-Approved Initiative Status and Impact Summary

Report Date:	8/22/2025	**Initiative Name:**	In-Home Care Pilot Program	**Start Date:**	9/1/2023
Reporting Period:	Apr-Jun (Q4)			**End Date:**	8/31/2025
Program Status:	In Progress	**Initiative Owner:**	Dr. Zeinab Dabbah	**Approved Amount:**	$2.0 Million
Payment Status:	Not Started				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health has contracted with UCI to partner with home-based care Dispatch Health services to provide services to CalOptima Health members assigned to a UCI FQHC with acute medical needs. The program provides same-day high acuity care, focused medical intervention within 24 to 72 hours post discharge, and hospital-at-home alternative care in lieu of hospitalizations.	- Received annual report (Jan 2024-Jun 2025); see metrics results reported below, with a total of 385 CalOptima Health members served from program start through Q2 2025. - CalOptima Health/UCI Health Center check-in meeting scheduled in August 2025 to discuss ongoing program status, utilization, and next steps.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Improve access to in-home acute care	Number of members seen in in-home acute care	385 members seen in in-home acute care that were referred by UCI FQHCs *Data is from Jan 2024 - Jun 2025
Reduce emergency department (ED) visits by 20%	Percentage of members seen through in-home acute care instead of ED	219 members seen in in-home care acute care *Data is from Jan 2024 - Jun 2025
Achieve utilization of Dispatch Health by at least 10%	911 Diversion Rate	24.5% of members were diverted to Dispatch Health in place of 911 service *Data is from Jan 2024 - Jun 2025
Reduce hospital observation stay by 10%	Observation Diversion Rate	5.8% of members seen by Dispatch Health were observed in ED *Data is from Jan 2024 - Jun 2025
Reduce hospital admission by 10%	Hospital Diversion Rate	3.4% reduction of hospital admission for members seen by Dispatch Health *Data is from Jan 2024 - Jun 2025

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Board-Approved Initiative Status and Impact Summary

Report Date:	8/6/2025	**Initiative Name:**	Member and Population Health Needs Assessment	**Start Date:**	3/14/2025
Reporting Period:	Apr-Jun (Q4)			**End Date:**	2/15/2026
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$1.3 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Conduct a comprehensive Member and Population Health Needs Assessment (MPHNA) and Health Equity Asset Mapping (HEAM) to assess the whole-person health needs and preferences of CalOptima Health members, inform the development of programs and strategic approaches and to meet the requirements of the Community Reinvestment program.	1) Provider surveys to launch in July 2025 2) Member surveys to launch in early fall 2025 3) Focus groups/interviews to launch in Q4 2025 4) Ongoing stakeholder engagement with Member and Provider Advisory committees, WCM Committee, Health Network Forum, Community Clinic Forum, and Population Health Collaborative w/ OCHCA

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Support meeting the requirements of DHCS population health initiatives, e.g., Population Health Management Strategy, (PNA), and Medi-Cal Transformation initiatives.	Deployment of MPHNA	- Preparing provider survey to launch in July - Awaiting membery survey materials approval from DHCS
Identify trends and opportunities in population health and social needs of CalOptima Health members.	MPHNA report findings produced	- Began analysis of secondary data by vendor NORC
Identify assets and resources avaliable in the community and conduct gap analysis.	Detailed community asset mapping and list of community investment opportunities through an interactive dashboard produced	TBD - not yet started
Develop recommendations for interventions based on assessment findings.	Final report with actionable strategies and recommendations developed and presented	TBD - not yet started. Report planned to be completed in Q1 2026.

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Board-Approved Initiative Status and Impact Summary

Report Date:	8/5/2025	**Initiative Name:**	Mind OC Grant (Irvine)	**Start Date:**	12/1/2022
Reporting Period:	Apr-Jun (Q4)			**End Date:**	7/31/2025 (extension)
Program Status:	In Progress	**Initiative Owner:**	Kelly Bruno-Nelson	**Approved Amount:**	$15.0 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Mind OC received grant funding to support the construction of the second Be Well OC Campus in Irvine, CA to provide mental health and substance abuse services to all, regardless of payer. The first phase of campus development will include 75,000 sq ft. of crisis care, outpatient and residential/short term treatment options. The services are planned to support a full continuum of care needs, and will offer programs for adults, adolescents, and families (through wraparound supports).	- CalOptima conducted site visit on 5/20/25. - Construction delays have been reported due to external dependencies resulting in request for contract amendment to extend term through 12/31/25; ongoing monitoring and mitigation planning in progress. - Remaining funds are being disbursed on a monthly basis; disbursed 5 of 8 monthly payments on 6/10/25.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Complete Package 1: Site Readiness activities, to prepare site for the construction of 75,000 square feet of the Be Well Irvine Campus – Phase 1	% of site readiness activities completed and scheduled	100% completed: Demolition, abatement, rough grading and future building pads completed by August 2023.
Complete Package 2 construction for Be Well OC Irvine Campus, and buildings ready for phased operational go-live.	% of building construction based on procurement and construction schedule	- 90% complete: completion of permanent power connection; landscaping was nearly completed throughout the site; interior details continue to be finalized. - Delays in construction activities; discussion in process for contract amendment to extend term through 12/31/2025; ongoing monitoring in process.
Align public and private funding to execute on the capital financing needed for Phase 1 development, for a total of $86 million.	$ amount of secured capital financing for funding Phase 1 development	100% completed: $82.7M in cash; $3.2M secure via fund flow contract with County of Orange.
Facilitate the process of provider selection and contracting for service provision at the Campus (OPTIONAL)	% completion of selection process and contracting for service providers	Objective is no longer applicable as the Orange County Health Care Agency terminated the Master Service Agreement with MindOC, and is now leading the effort to select providers.

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Board-Approved Initiative Status and Impact Summary

Report Date:	8/6/2025	**Initiative Name:**	Naloxone Distribution Event	**Start Date:**	07/01/23
Reporting Period:	Apr-Jun (Q4)			**End Date:**	07/01/25
Program Status:	Complete	**Initiative Owner:**	Veronica Carpenter	**Approved Amount:**	$15.0 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Naloxone Distribution initiative aims to increase access to Naloxone for members, with the goal of reversing fentanyl and opioid overdoses and saving lives.	- CalOptima Health has fully distributed 250,000 boxes of Naloxone via events and mail order option. Program is complete. - $2.0 m in unspent funds approved for reallocation/return to funding source. Payment is complete.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Purchase 250,000 doses of naloxone for distribution	Purchase Kloxxado (8 ml prescription-strength naloxone)	250,000 boxes of Naloxone were purchased and have been fully distributed in the community.
Conduct events and community outreach to distribute naloxone to members	Offer naloxone at community events in various places throughout the county	CalOptima Health hosted 1 member distribution event and two provider/community-based organization distribution events. Naloxone distribution was also included in 10+ community events hosted by CalOptima Health.
Engage providers, community organizations, city governments, public agencies, school districts and others in helping to distribute naloxone to members	Create a process for providers and other partners to obtain the naloxone using a distribution agreement	CalOptima Health established a mail order option and has fully distibuted the full supply of Naloxone.
Create a training video and communications resources to promote naloxone distribution and education	Develop sharable resources for communications and education	Communications developed a Naloxone toolkit and campaign to promote our Naloxone efforts. The toolkit included "How to Administer Naloxone" and FAQs for members, providers and communty stakeholders' use.
Establish a partnership with recovery coalitions to provide access to Naloxone	Offer an ongoing and routine allocation of Naloxone for members who are affiliated with a recovery coaltion.	CalOptima Health established a relationship with the Recovery Coalition to distribute Naloxone in the community.

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Board-Approved Initiative Status and Impact Summary

Report Date:	8/13/2025	**Initiative Name:**	NAMI Orange County Peer Support Program	**Start Date:**	1/1/2023
Reporting Period:	Apr-Jun (Q4)			**End Date:**	12/31/2027
Program Status:	In Progress	**Initiative Owner:**	Carmen Katsarov	**Approved Amount:**	$5.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
NAMI pairs trained Peer Support Mentors with CalOptima Health members to provide tailored, social support and resource navigation from hospital inpatient stay/emergency room visit to six months post-discharge. Peer Support Mentors support members in scheduling and attending follow-up primary care appointments (especially post-discharge).	- Amendment was processed to allow budget reallocation; indicated no change in overall budget and scope of work, and no impact to goals/objectives. - Released #4 payment disbursement based on approved semi-annual progress report #3 in June.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Facilitate behavioral health transitions from hospital to home/community	Facilitate behavioral health transitions for 65% of those who are referred to the program (N=eligible members referred from hospital or ED). Success = 2+ months	In progress to update process to include FQHC partnership and CalOptima Health partnership referrals as only ED contract currently is with Hoag. As of June, current FQHC partnership in progress to adapt program.
Support behavioral health integration through Peer facilitating member connection to ECM.	NAMI Peer program, connect 75% of members eligible for ECM who aren't already receiving the benefit (i.e., the member receives an authorization for ECM)	As of May 2025, referral to ECM only given to eligible participants. Expanding ECM partnerships. -June 2025: 12 participants engaged in services while 14 are contemplating -May 2025: 12 participants engaged in services, 4 of which are 4/2025 referrals
Improve CalOptima Health's HEDIS FUM1 measure	For members who are referred to the program, 85% achieve a follow-up appointment either 7 or 30 days after hospital or ED discharge	Current ED contract with Hoag. In progress to update current process due to challenges with discharged participants no longer interested in program/perceive services no longer needed.
Reduce readmissions at psychiatric hospital through family and resource connection	25% reduction in psychiatric hospital admissions for members referred from the ED and having completed the program	Started May 2025. Results to be shared at next semi-annual report due 11/30/25.
	25% reduction in psychiatric hospital re-admissions for members referred during an inpatient stay *Establish baseline during year 1*	Started May 2025. Results to be shared at next semi-annual report due 11/30/25.

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Board-Approved Initiative Status and Impact Summary

Report Date:	8/21/2025	**Initiative Name:**	OneCare Member Engagement and Education - Star Rating	**Start Date:**	06/26/2025
Reporting Period:	Apr-Jun (Q4)			**End Date:**	06/30/2026
Program Status:	In Progress	**Initiative Owner:**	Javier Sanchez	**Approved Amount:**	$300,000
Payment Status:	Not Started				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The goal of the OneCare Member Engagement and Education initiative is to develop a comprehensive outreach and engagement plan to maximize current OneCare members' engagement in order to improve OneCare star ratings. (Note: this is a pilot with a target of reaching 500 OneCare members.)	- Contract with Wider Circle executed on 6/26/2025. Next steps: project kickoff, data development and delivery to Wider Circle, outeach/recruitment and development of engagement groups that will encourage and support the members to complete health-related activities.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Annual Wellness Visit completion rate to improve.	Must improve from current rate of 36% to 66% or greater for the target population.	Not started
OneCare member attrition rate to be reduced.	Must improve from current voluntary disenrollment rate of 12.07% to 10-12% for the target population.	Not started
Health Risk Assessment completion rate to improve.	Must improve from current rate of 65% to 70% or greater for the target population.	Not started

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Board-Approved Initiative Status and Impact Summary

Report Date:	8/15/2025	**Initiative Name:**	OneCare Outreach and Engagement Strategy	**Start Date:**	07/01/2024
Reporting Period:	Apr-Jun (Q4)			**End Date:**	6/30/2025
Program Status:	Complete	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$1.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Expansion of the CalOptima Health OneCare outreach and engagement strategy to enroll and retain eligible CalOptima Health members who are also enrolled in Medicare.	Funds are fully allocated - outcomes are included below.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Increase outreach for CalOptima Health OneCare through continuous and heavy presence in the market with a full range of advertising tactics.	Number of media buys	For Q4, we launched out-of-home, place-based ads at senior centers, pharmacies, clinics/point-of-care, grocery stores, Walmart stores, Western Union locations, restaurants, retail/recreation centers and digital bulletins. In all, the campaign was featured in 200 locations, plus over 800 programmatic digital screens.
Retain existing CalOptima Health OneCare members with targeted mailings.	Number of members retained	In FY24 we sent two retention mailers to members, which resulted in decreased disenrollment (i.e. increased retention) of 8.5% and 5.9%, respectively for April 2024 and June 2024.
Increase direct mail outreach to prospective OneCare members by customizing messages and segmenting the mailing.	Number of mailers sent to three segmented audiences (fee-for-service members, members of another Medicare Advantage plan, former OneCare members)	This strategy was implemented in October 2024 with FY25 budget funds and in coordination with the new campaign roll out.

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Board-Approved Initiative Status and Impact Summary

Report Date:	8/13/2025	**Initiative Name:**	Provider Workforce Development	**Start Date:**	12/1/2023
Reporting Period:	Apr-Jun (Q4)			**End Date:**	FY 2028-2029
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$50.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Provider Workforce Development Initiative was approved to close gaps in Orange County ' s health care workforce and increase access to high-quality, equitable care for CalOptima Health members. The five initiatives include: educational investments to increase supply of health care professionals (non-physician), the Workforce Training & Development Innovation Fund, the Physician Recruitment Incentive Program, the Physician Loan Repayment Program, and the Orange County Health Care Workforce Development Collaborative.	- Ongoing progress monitoring for WFD round 1 grantees (educational institutions); completed semi-annual check-ins with grantees. - Ongoing progress monitoring for WFD round 2 grantees (behavioral health); planning for first quarterly check-ins with grantees. - Released an RFP for a contractor/organization to support the OC Health Care Workforce Development Collaborative.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Implement Educational investments to increase supply of health care professionals (non-physician)	Number of health professionals in an educational program and/or receiving financial support	- Projected 1,000 health professionals, including nursing, physician assistant, and allied health student recipients by end of 2029
Launch Workforce Training & Development Innovation Fund	Number of behavioral heath care professionals receiving training and/or development	Approximately 800 total behavioral students/health professionals recipients by end of 2029
Implement Physician Recruitment Incentive Program	Number of physicians recruited to close network gaps	TBD - Not started
Implement Physician Loan Repayment Program	Number of physicians receiving loan repayment awards	TBD - Not started
Develop Orange County Health Care Workforce Development Collaborative	Launched collaborative to increase the health care workforce in Orange County	TBD - RFP in process for contractor to support the collaborative

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Community Investment Status Report
Initiative: Provider Workforce Development

Partner Organization	NOFO Round	Program Title	Program Dates	Program Metrics	Grant Amount	Payments To Date	Grant Status
Chapman University	1	Reflecting OC Communities: Building a Culture of health through PA scholarships,training, local practice	7/1/24 - 12/31/29	7/24-11/24: 4 PA Students received full tuition scholarships	$ 5,000,000	$ 413,025	In Progress
Coast Community College District	1	Orange County Dual Enrollment Nursing and Allied Health Pathways	5/1/24 - 5/31/28	5/24-10/24: Golden West College nursing pipeline implementation	$ 2,040,000	$ 420,000	In Progress
Concordia University	1	Concordia Nursing Pipeline Program	8/1/24 - 8/1/29	8/24-1/25: 29 ABSN and pre-nursing students awarded scholarships	$ 5,000,000	$ 792,880	In Progress
CSU Fullerton Auxiliary Services Corporation	1	Expanding Numbers of CSUF Baccalaureate-Prepared Registered Nurses in OC	7/1/24 - 6/30/29	7/24-1/25: 10 RN-BSN stipend recipients; 54 BSN received stipends	$ 5,000,000	$ 971,357	In Progress
Orange County United Way	1	UpSkill OC	5/1/24 - 4/30/27	5/24-10/24: 17 UpSkill participants enrolled in healthcare career track	$ 1,356,300	$ 452,100	In Progress
Rancho Santiago Community College District	1	SCC Healthcare Pathways - Behavior Technician, LVN and Medical Assistant Projects	5/1/24 - 6/30/27	5/24-11/24: Classroom for Medical Assistant secured	$ 1,200,000	$ 775,219	In Progress
UCI Sue & Bill Gross School of Nursing	1	Nurse-OC: UCI Nursing Workforce Pipeline through Externships and Residencies in Orange County	5/1/24 - 6/30/29	5/24-10/24: 15 prelicensure nursing students placed in externship	$ 5,000,000	$ 538,869	In Progress
Child Guidance Center	2	Help the Helper: Strengthening Orange County's Behavioral Health Workforce	1/1/25 - 12/31/27	1/25-3/25: 29 graduate student interns; expanded to 21 university partnerships	$ 766,920	$ 216,810	In Progress
CHOC	2	Pediatric Behavioral Health Field Training Expansion	1/1/25 - 12/31/28	1/25-3/25: 30 MSW intern interviews conducted	$ 994,824	$ 248,706	In Progress
John Henry Foundation	2	Psychologist and MFT Workforce Development Program	1/1/25 - 12/31/29	1/25-3/25: 5 interns onboarded	$ 847,302	$ 155,390	In Progress
Seneca Family of Agencies	2	Seneca Family of Agencies Orange County Behavioral Health Clinical Internship Program	3/1/25 - 6/30/28	Goal: train 18 master's students in mental health	$ 996,160	$ 179,030	In Progress
Special Service for Groups	2	Professional Providers Pathway Program	1/1/25 - 12/31/29	1/25-3/25: 7 interns interviewed for second year practicum	$ 535,566	$ 106,622	In Progress
Western Youth Services	2	WYS Workforce Development Program	1/1/25 - 12/31/29	1/25-3/25: Interns to begin Fall 2025; Staff reimbursements requests submitted	$ 1,000,000	$ 200,000	In Progress
					$	$	
					$	$	
					$	$	

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Board-Approved Initiative Status and Impact Summary

Report Date:	8/18/2025	**Initiative Name:**	Stipend Program for Masters of Social Work	**Start Date:**	8/1/2023
Reporting Period:	Apr-Jun (Q4)			**End Date:**	7/31/2028
Program Status:	In Progress	**Initiative Owner:**	Kelly Bruno-Nelson	**Approved Amount:**	$5.0 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Orange County Behavioral Health (OCBH) Master of Social Work Stipend Program will increase the public healthcare workforce from diverse backgrounds equipped to provide culturally and linguistically responsive care to communities in need. The program will provide a stipend of $20,000 per academic year for up to two (2) years to 36 MSW students each year at CSUF (as they receive enhanced didactic and experiential training).	- 36 students successfully enrolled in the OCBH program for 2024-2025 academic year: 21 students are continuing from 2023-2024 academic year; 15 new first year MSW award recipients - 14 grant recipients graduated between May-August 2024 and confirmed a one-year work commitment within Orange County - Simucase, the online learning platform, has been integrated into all MSW advanced practicum courses - The next grantee progress report is due in September 2025.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Double the number of MSW field placements that focus on behavioral health practice with persons from vulnerable communities from 70 to 140 over 5 year grant period.	Number of MSW field placements	-70 MSW students placed in 2023-2024; 100 MSW students placed in 2024-2025 -25 new placement spots added for students within new and existing partner agencies
Award stipends to 108-180 MSW students who fully participate in the CalOptima Health MSW Stipend Program over 5 year grant period.	Number of students completing the Grant Program	-2023-2024 academic year: 36 stipends awarded; 14 recipients graduated in May -2024-2025 academic year: 36 stipends awarded; 21 to second year MSW students; 15 to first year MSW students -Total of 51 total unique MSW students awarded stipends over grant life cycle
Develop an enhanced curriculum on behavioral health including digital health literacy and telehealth.	Students' clinical competency measured by quantitative and qualitative evaluation methods	Enhanced online curriculum provided through stipend program: - Simucase learning platform as part of advanced practice - Cognitive Behavioral Therapy training: 88.9% of students reported applying the knowledge and skills learned from CBT training in field practicum
Offer career development services to all CalOptima Health MSW Stipend Program students and follow up regarding employment at 1-year post-graduation.	Number of former students with post-graduate employment	-Year 1 Post-graduation employment survey indicate all 14 graduated stipend recipients retained employment in Orange County within six months of graduation

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Board-Approved Initiative Status and Impact Summary

Report Date:	8/13/2025	**Initiative Name:**	Wellness Prevention Program	**Start Date:**	7/1/2024
Reporting Period:	Apr-Jun (Q4)			**End Date:**	6/30/2028
Program Status:	In Progress	**Initiative Owner:**	Carmen Katsarov	**Approved Amount:**	$2.7 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
This project will supplement the Mental Health Service Oversight and Accountability Commission (MHSOAC) funding to support establishment of full clinical operations and prepare Allcove South Orange County Youth Drop in Center to create sustainable service streams. Delivery of services will be supported by FTE positions learning opportunities through Stanford CAT.	- Approved limited change request indicating no change to SOW; amendment #2 was processed in June. - Upcoming progress report #4 due in July. - Check-in with grantee scheduled to take place in August.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Secure a location for Allcove in South Orange County	Location secured successfully	Completed 10 year lease effective 5/6/2024. Soft opening 8/18/25.
Staff recruitment	Number of hired staff - positions to support delivery of care services in allcove model	In process, full staff hiring anticipated completion 10/31/25. Current open roles are for a Clinical Director and Youth Outreach Specialist.
Establish intake data collection	Data collection system implementation	In process of contracting for an EHR service.

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Board-Approved Initiative Status and Impact Summary

Report Date:	8/18/2025	**Initiative Name:**	Homeless Prevention and Stabilization Pilot Program	**Start Date:**	1/1/2025
Reporting Period:	Apr-Jun (Q4)			**End Date:**	1/01/2028
Program Status:	In Progress	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$269,703
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
To evaluate the effectiveness of the Homeless Prevention and Stabilization program (HPSP) using a combination of administrative data and data from surveys that will be administered by faculty at the University of California, Irvine. Data will be collected for both the program participants (treatment group) and a sample of similar individuals not enrolled into the program (comparison group). HPSP aims to assist approximately 200 families and will be rolled out over a two year period.	The evaluation program has launched and is in progress. The first two payments have been released, and the first report has been received.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Complete cohort baseline surveys, complete cohort 1 6-month surveys, and provide status update on data analysis and findings	Report #1	As of June 1, 2025, the research team has received 148 completed baseline surveys for Cohort 1 (39 from program participants and 109 from comparison group). The team also received 17 6-month surveys (10 participant; 7 comparison). Recruitment is still underway and data analysis has yet to begin.
Complete cohort 2 baseline surveys and provide status update on data analysis and findings	Report #2	TBD
Complete cohort 1 18-month surveys, complete cohort 2 6-month surveys, and provide status update on the data analysis and findings	Report #3 and #4	TBD
Complete cohort 2 18-month survey ad provide a status report update on the data analysis and findings	Report #5	TBD
Provide a draft evaluation report and final evaluation report	Report #6 and #7	TBD

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Board-Approved Initiative Status and Impact Summary

Report Date:	8/15/2025	**Initiative Name:**	Comprehensive Community Cancer Screening and Support Program	**Start Date:**	12/02/2022
Reporting Period:	Apr-Jun (Q4)			**End Date:**	12/31/2027
Program Status:	In Progress	**Initiative Owner:**	Dr. Richard Pitts	**Approved Amount:**	$50.1 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Comprehensive Community Cancer Screening and Support Program aims to create a culture of cancer prevention, early detection and collaboration with partners to work towards a shared goal of dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have equitable access to high quality care.	Accomplishments: 1) Conducted in-person grantee meeting for Progress Report #2. 2) Developed grantee dashboard with new HEDIS engine, showing baseline/progress/and 'gap to close.' 3) Launched 2-way texting campaigns (breast cancer screening, cervical cancer screening, colorectal cancer screening) and translated trigger responses for better data. Opportunity: In collaboration with Grant Programs team, initiated grant amendments to include: 1) 6-month no-cost extension to grant program, 2) Increased payment frequency,

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Increase community and member awareness and engagement	Develop and launch a multimedia, multilingual campaign within the first four years of the program (*Data provided by Maricich)	90.2 Million campaign digital ad impressions; 0.31% Click-through rate (CTR); 42 million digital added value impressions; 15.3 million completed video views; 247.7K digital clicks to landing page
Increase access to cancer screening for eligible member	Develop and implement a community grant initiative by year two of the Cancer Screening and Support program	Round 1 grants successfully launched in September 2024. Since then, all 15 grantees have been actively working to increase access to cancer screening services.
	# of CalOptima members who received appropriate cancer screening	BCS (Breast Cancer Screening): 4,684 CCS (Cervical Cancer Screening): 10,833 COL (Colorectal Cancer Screening): 9,417 Lung (Lung Cancer Screening): 727
Improve quality and member experience during cancer screening and treatment procedures	Extend vendor contract(s) to support members through screening, diagnosis and cancer treatment starting in Year 2	Community grants are supporting this metric: mPulse is outreaching to members via text for general cancer awareness, screening information, and support during treatment.
	Establish contract to evaluate cancer incidence, experiences, and genomic technologies to reduce disparities in late-stage cancer diagnosis by Year 2	Continue working on refining the scope of work for the research and evaluation initiative.

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Community Investment Status Report
Initiative: Cancer Screening and Support

Partner Organization	NOFO Round	Program Title	Program Dates	Program Metrics	Grant Amount	Payments To Date	Grant Status
American Cancer Society, Inc.	1	Advancing Equitable Outcomes Across the Cancer Continuum for CalO Members and Greater OC Area	9/1/24 - 12/31/26	3 health systems were recruited for QI projects. 5 health systems were	$ 1,500,000	$ 375,000	In Progress
Celebrating Life Community Health Center	1	Using Technology Infrastructure to Close Gaps in CCS	9/1/24 - 12/31/26	Formalized vendor contracts, installed reporting and population health systems,	$ 329,428	$ 82,357	In Progress
Celebrating Life Community Health Center (2)	1	Closing Gaps in Cancer Screening	9/1/24 - 12/31/26	BCS: 1011 screenings conducted CCS: 3117 screenings conducted	$ 1,290,575	$ 322,643.75	In Progress
Families Together of Orange County	1	C3 Health Initiative: Cervical, Colorectal and Breast Cancer Screening Program - Capacity Building	9/1/24 - 12/31/26	BCS: 533 screenings conducted CCS: 819 screenings conducted	$ 1,500,000	$ 375,000	In Progress
Friends of Family Health Center	1	Standardizing Screening Mammograms within Primary Care Setting	9/1/24 - 12/31/26	BCS: 456 screenings conducted CCS: 356 screenings conducted	$ 554,875	$ 138,718.75	In Progress
Hurtt Family Health Clinic, Inc.	1	Universal Cancer Screening Program: SDOH, Patient Motivation to Early Detection & Timely Access to Care	9/1/24 - 12/31/26	BCS: 70 screenings conducted CCS: 206 screenings conducted	$ 1,018,600	$ 254,650	In Progress
Korean Community Services, Inc.	1	Orange County Asian American Cancer Partnership (OCAACP)	9/1/24 - 8/31/26	BCS: 1160 screenings conducted CCS: 992 screenings conducted	$ 3,000,000	$ 750,000	In Progress
Laguna Beach Community Clinic	1	Cancer Screening and Support for Disadvantaged Patients	9/1/24 - 12/31/26	BCS: 32 screenings conducted CCS: 406 screenings conducted	$ 116,000	$ 29,000	In Progress
Latino Health Access	1	Juntes Contra el Cancer! / Together Against Cancer!	9/1/24 - 12/31/26	248 unique CalO members received peer support services. A total of 696	$ 1,500,000	$ 375,000	In Progress
mPULSE Mobile, Inc.	1	Equitable Cancer Prevention with Targeted Member Screening Communications	9/1/24 - 8/31/26	BCS 2-way (unique members: 55,541) CCS 2-way (unique members: 81,018)	$ 1,197,625	$ 299,406.25	In Progress
Share Ourselves Corporation	1	Share Ourselves: Cancer Screening	9/1/24 - 12/31/26	BCS: 941 screenings conducted CCS: 2340 screenings conducted	$ 362,500	$ 90,625	In Progress
The G.R.E.E.N Foundation	1	Increasing Screening and Health Equity in OC	9/1/24 - 12/31/26	1,735 phone calls made. Initial agendas for collaborative health education	$ 295,100	$ 73,775	In Progress
UCI Family Health Center	1	Closing the Cancer Screening Gap	9/1/24 - 12/31/26	BCS: 481 screenings conducted CCS: 500 screenings conducted	$ 1,500,000	$ 375,000	In Progress
AltaMed	1	Comprehensive Community Cancer Program - Capacity Building (CCCP-CB)	9/1/24 - 12/31/26	CCS: 2097 screenings conducted Lung: 91 screenings conducted	$ 1,499,992	$ 374,998	In Progress
AltaMed (2)	1	Comprehensive Community Cancer Program - Infrastructure and Capital Improvements (CCCP-ICI)	9/1/24 - 12/31/26	The EPIC Boost Analyst and Compass Rose Schematics are on track for	$ 752,349	$ 188,087.25	In Progress
					$	$	

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Board-Approved Initiative Status and Impact Summary

Report Date:	8/18/2025	**Initiative Name:**	Dyadic Services Program Academy	**Start Date:**	6/1/2024
Reporting Period:	Apr-Jun (Q4)			**End Date:**	5/31/2026
Program Status:	In Progress	**Initiative Owner:**	Carmen Katsarov	**Approved Amount:**	$1.9 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
First 5 Orange County (F5OC) will develop and provide administrative oversight of the CalOptima Health Dyadic Services Program Academy to expand dyadic services capacity. The academy's objective is to increase access to HealthySteps dyadic services for members by launching 10 sustainable dyadic services programs across Orange County. F5OC will provide pre-academy planning and development, a 9-month academy, and 12-month post-academy technical assistance for each clinic.	- Academy started on schedule and in process with 7 of the 10 clinics participating. The last three will be recruited in Q3 of 2025. - Baseline data received on participating clinics which will enable accurate outcome reporting on the key objectives. - First utilization report due in August 2025.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Train 10 clinics to complete the Academy and obtain HealthySteps certification.	Number of clinics that completed the Dyadic Care Training Academy and obtained required HealthySteps certification	- 7 clinics have participated in the Academy and 4 clinics have recruited a HealthySteps Specialist and are well into the onboarding phase with 0 to 3 for HealthySteps orientation and training. - The remaining clinics continue to progress.
Increase members receiving well child visits and screenings.	Claims/encounter data on well child visits and screenings	Academy started on schedule and still in process. Baseline data for participating clinics submitted. Will report back when academy is completed and utilization reports are submitted.
Increase billing for Dyadic Services and non-speciality mental health.	Claims/encounter data on dyadic services and mental health services	Academy started on schedule and still in process. Baseline data for participating clinics submitted. Will report back when academy is completed and utilization reports are submitted.

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Board-Approved Initiative Status and Impact Summary

Report Date:	8/15/2025	**Initiative Name:**	Five-Year Hospital Quality Program	**Start Date:**	1/1/2023
Reporting Period:	Apr-Jun (Q4)			**End Date:**	12/31/2028
Program Status:	In Progress	**Initiative Owner:**	Linda Lee	**Approved Amount:**	$153.5 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Hospital Quality Program for CalOptima Health-contracted hospitals aims to improve quality of care to members through increased quality and patient safety efforts. Program goals: 1) Support hospital quality standards for Orange County; 2) Provide industry benchmarks and data-driven feedback; 3) Recognize hospitals demonstrating quality performance; 4) Provide comparative information on network hospitals; and 5) Identify areas for improvement.	CalOptima Health held a meeting with hospital CEOs on May 2, 2025 to discuss options for utilizing unearned hospital quality funds for quality improvement efforts. Hospitals to provide feedback to CalOptima Health for potential enhancements to the Hospital Quality Program.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Reward contracted Medi-Cal hospitals for high performance on hospital quality of care, patient experience, and hospital safety using CMS hospital quality and Leapfrog patient safety measures.	The percentage of contracted hospitals earning hospital quality incentives. Metric equals number of hospitals earning any incentive amount divided by number of eligible contracted hospitals.	Hospitals are submitting MY2024 data to CMS and Leapfrog. Data will be available starting July 2025.
	The percentage of hospital quality dollars awarded. Metric equals total incentives awarded divided by total annual incentive pool.	Hospitals are submitting MY2024 data to CMS and Leapfrog. Data will be available starting July 2025.
Improve hospital quality	Star Rating	Hospitals are submitting MY2024 data to CMS and Leapfrog. Data will be available starting July 2025.
Improve hospital patient experience	Star Rating	Hospitals are submitting MY2024 data to CMS and Leapfrog. Data will be available starting July 2025.
Improve hospital patient safety	Safety Grade	Hospitals are submitting MY2024 data to CMS and Leapfrog. Data will be available starting July 2025.

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Hospital Quality Stars Rating

Hospital	Hospital Quality STARS Rating	Hospital Patient Survey Rating	Leapfrog Hospital Safety Guide	Maximum Incentive Possible	Incentive Earned
Anaheim Regional Medical Center	★★★	★★	B	$1,413,638	$494,773
Anaheim Global Medical Center	N/A	★★	C	$265,834	$26,583
Chapman Global Medical Center	★	★	D	$155,157	$0
Children's Hospital of Orange County	★★★★★	★★★★★	B	$3,598,119	$3,418,213
Foothill Regional Medical Center	N/A	★	N/A	$627,218	$0
Fountain Valley Regional Hospital & Medical Center	★★	★	D	$3,456,890	$0
Hoag Memorial Hospital Presbyterian	★★★★★	★★★★	A	$1,940,663	$1,746,597
Los Alamitos Medical Center	★	★★	D	$404,816	$0
Memorial Care Long Beach Medical Center	★★	★★★	C	$207,276	$62,183
Memorial Care Miller Children's and Women's Hospital	★★	★★★	C	$ –	$ –
Memorial Care Orange Coast Medical Center	★★★★	★★★	C	$1,120,696	$672,418
Memorial Care Saddleback Medical Center	★★★	★★★	B	$412,305	$226,768
Orange County Global Medical Center	★	★★	D	$2,013,149	$0
Placentia Linda Hospital	★★	★★★	C	$360,336	$108,101
Pomona Valley Hospital Medical Center	★★★★	★★★	A	$29,354	$20,548
Providence Mission Hospital	★★★★	★★★	B	$1,305,806	$848,774
Providence St. Joseph Hospital	★★★★	★★★★	B	$2,881,640	$2,161,230
Providence St. Jude Medical Center	★★★★	★★★	B	$1,355,978	$881,386
South Coast Global Medical Center	N/A	★	D	$359,887	$0
UCI Medical Center	★★★★	★★★★	A	$5,881,296	$4,705,037
Whittier Hospital Medical Center	★★★	★★	B	$53,167	$18,608
	TOTALS			**$27,843,225**	**$15,391,218**

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Board-Approved Initiative Status and Impact Summary

Report Date:	8/12/2025	**Initiative Name:**	Quality Initiatives from Unearned P4V Program	**Start Date:**	7/1/2024
Reporting Period:	Apr-Jun (Q4)			**End Date:**	12/31/2025
Program Status:	In Progress	**Initiative Owner:**	Linda Lee	**Approved Amount:**	$23.3 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health implements an annual Pay for Value Program (P4V) to promote high quality outcomes and improvement in quality measures among Health Network and CalOptima Health Care Network (CCN) primary care physicians (PCPs). Each year providers earn a portion of allocated incentive dollars and forfeit a portion of incentive dollars by not achieving the highest benchmarks. Starting with the measurement year 2023 P4V program, the Board approved the use of unearned incentive dollars towards quality initiatives.	All grantees (37 of 37) have submitted 6-Month Progress Reports. CalOptima Health staff are reviewing reports for compliance with grant project deliverables and timelines.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Stimulate improvement on lower performing quality measures by issuing grants to Health Networks and CCN PCPs for the implementation of quality improvement initiatives	Number of grant awards among Health Networks for Medi-Cal measures	17 grants were awarded to five Health Networks; totaling $2,940,120
	Number of grant awards among CCN PCPs for Medi-Cal measures	15 grants were awarded across 12 organizations totaling $2,052,492
	Number of grant awards among Health Networks for OneCare measures	5 grants were awarded to five Health Networks; totaling $1,028,628
Number of grant awards among CCN PCPs for Medi-Cal measures	(attachment)	

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Medi-Cal Quality Initiatives

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
1			CCN		HPN-Regal		OPTUM		Prospect		Family Choice		CHOC		AMVI Care		Noble		AltaMed		UCMG	
2	Clinical Measure (HEDIS)	Submeasure	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile
3	Breast Cancer Screening (BCS-E)	Non-MCR Total	58.47%	67th	58.45%	67th	51.28%	33rd	59.32%	67th	59.58%	67th	0.00%	<10th	66.52%	90th	51.14%	33rd	53.90%	33rd	55.08%	67th
4	Cervical Cancer Screening (CCS)		61.30%	67th	50.75%	10th	53.15%	10th	55.88%	33rd	61.20%	67th	4.31%	<10th	54.54%	33rd	46.03%	10th	57.85%	33rd	53.74%	33rd
5	Child and Adolexcent Well-Care Visits (WCV)	Total	47.07%	33rd	32.35%	<10th	47.69%	33rd	43.45%	10th	53.05%	67th	59.44%	67th	55.25%	67th	46.85%	33rd	41.17%	10th	51.98%	67th
6	Childhood Immunization Status (CIS)	Combo 10	29.60%	33rd	24.16%	10th	27.78%	33rd	41.08%	67th	45.58%	90th	35.64%	67th	34.98%	33rd	32.29%	33rd	41.64%	67th	57.93%	90th
7	Chlamydia Screening in Women (CHL)	Total	72.56%	90th	67.38%	67th	64.16%	67th	67.90%	90th	67.75%	90th	79.93%	90th	83.10%	90th	64.36%	67th	78.93%	90th	64.14%	67th
8	Controlling High Blood Pressure (CBP)		72.43%	90th	57.54%	10th	72.15%	67th	77.12%	90th	69.68%	67th	40.46%	<10th	93.52%	90th	84.12%	90th	82.01%	90th	61.54%	33rd
11	Hemoglobin A1c Control for Patients with Diabete	Poor Control	30.39%	67th	18.14%	90th	34.84%	33rd	37.56%	33rd	47.70%	10th	62.11%	<10th	12.81%	90th	26.50%	90th	27.00%	90th	18.12%	90th
12	Immunizations for Adolescents (IMA)	Combo 2	35.51%	33rd	23.92%	<10th	39.37%	67th	43.24%	67th	47.36%	67th	49.66%	90th	56.27%	90th	45.34%	67th	48.23%	67th	48.74%	67th
13	Lead Screening in Children (LSC)		62.71%	33rd	15.38%	<10th	55.93%	33rd	68.57%	67th	67.89%		64.75%	33rd	64.41%	33rd	64.74%	33rd	78.32%	67th	66.15%	33rd
14	Prenatal and Postpartum Care (PPC)	Postpartum	83.55%	67th	77.82%	33rd	72.62%	10th	53.04%	<10th	70.44%	10th	79.94%	33rd	70.05%	10th	64.63%	<10th	81.20%	67th	74.46%	10th
15	Prenatal and Postpartum Care (PPC)	Prenatal	92.11%	90th	85.63%	33rd	82.22%	33rd	72.54%	<10th	64.20%	<10th	82.96%	33rd	83.58%	33rd	83.50%	33rd	89.23%	67th	58.12%	<10th
16	Well-Child Visits in the First 30 Months of Life (W3	First 15 Months	53.18%	10th	50.00%	10th	60.46%	33rd	67.44%	67th	49.32%	10th	56.50%	33rd	67.02%	67th	57.14%	33rd	64.04%	67th	55.36%	33rd
17	Well-Child Visits in the First 30 Months of Life (W3	15 Months - 30 Months	70.73%	67th	54.55%	<10th	72.26%	67th	74.75%	67th	79.92%	90th	73.13%	67th	68.91%	33rd	71.25%	67th	57.89%	10th	73.86%	67th
18	Satifaction Measure (CAHPS)		Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percetile	Rate	Percetile	Rate	Percentile	Rate	Percentile
19	Adult Care Coordination (Usually + Always)		84.62%	33rd	69.77%	<10th	82.14%	10th	88.89%	67th	80.00%	10th	81.25%	10th	72.73%	<10th	78.57%	10th	83.72%	33rd	71.05%	<10th
20	Adult Customer Service (Usually + Always)		85.71%	10th	83.79%	<10th	92.22%	90th	80.57%	<10th	83.02%	<10th	78.57%	<10th	81.82%	<10th	89.95%	33rd	90.16%	33rd	84.41%	<10th
21	Adult Getting Care Quickly (Usually + Always)		79.62%	33rd	81.79%	33rd	73.12%	<10th	76.94%	10th	72.88%	<10th	73.46%	10th	66.95%	<10th	75.29%	10th	73.95%	10th	73.51%	10th
22	Adult Getting Needed Care (Usually + Always)		80.96%	33rd	80.68%	33rd	75.49%	10th	77.80%	10th	73.13%	<10th	76.42%	10th	67.69%	<10th	81.30%	33rd	81.53%	33rd	72.31%	<10th
23	Adult Rating of Health Care (9+10)		67.71%	90th	55.29%	33rd	40.91%	<10th	44.55%	<10th	53.41%	10th	56.25%	33rd	50.88%	10th	52.54%	10th	63.86%	90th	44.93%	<10th
24	Adult Rating of Health Network (9+10)		59.17%	10th	53.69%	10th	52.08%	<10th	59.56%	33rd	53.08%	10th	68.92%	90th	50.66%	<10th	59.29%	10th	60.84%	33rd	50.61%	<10th
25	Adult Rating of PCP (9+10)		75.81%	90th	63.71%	10th	66.34%	33rd	65.38%	33rd	60.51%	<10th	83.67%	90th	59.62%	<10th	77.33%	90th	68.13%	33rd	64.91%	10th
26	Adult Rating of Specialist (9+10)		62.32%	10th	63.64%	10th	59.26%	<10th	59.74%	<10th	59.04%	<10th	55.56%	<10th	60.38%	<10th	72.73%	90th	76.47%	90th	51.67%	<10th
27	CAHPS Measure		Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percentile	Rate	Percetile	Rate	Percetile	Rate	Percentile	Rate	Percentile
28	Child Care Coordination (Usually + Always)		71.43%	<10th	90.00%	90th	80.77%	10th	78.57%	10th	72.00%	<10th	71.88%	<10th	60.00%	<10th	77.27%	10th	90.48%	90th	70.97%	<10th
29	Child Customer Service (Usually + Always)		86.49%	10th	89.29%	33rd	90.70%	67th	81.62%	<10th	75.00%	<10th	86.27%	10th	78.95%	<10th	89.19%	67th	87.50%	33rd	78.68%	<10th
30	Child Getting Care Quickly (Usually + Always)		75.82%	<10th	90.91%	90th	79.95%	10th	80.22%	10th	81.05%	10th	87.10%	33rd	79.41%	10th	75.75%	<10th	87.50%	33rd	81.46%	10th
31	Child Getting Needed Care (Usually + Always)		72.33%	<10th	78.24%	10th	68.45%	<10th	79.37%	10th	68.14%	<10th	75.70%	10th	71.57%	<10th	74.60%	<10th	84.45%	33rd	68.94%	<10th
32	Child Rating of Health Care (9+10)		50.00%	<10th	50.00%	10th	62.64%	10th	61.11%	<10th	53.85%	<10th	55.13%	<10th	47.62%	<10th	58.90%	<10th	59.68%	<10th	65.42%	10th
33	Child Rating of Health Network (9+10)		55.48%	<10th	59.65%	33rd	67.50%	10th	59.49%	<10th	54.05%	<10th	68.00%	10th	43.44%	<10th	65.66%	10th	68.64%	10th	52.63%	<10th
34	Child Rating of PCP (9+10)		70.69%	10th	63.41%	10th	72.00%	10th	60.95%	<10th	59.35%	<10th	70.34%	<10th	55.13%	<10th	75.00%	33rd	77.78%	33rd	69.74%	<10th
35	Child Rating of Specialist (9+10)		71.43%	33rd	62.50%	10th	77.78%	90th	72.41%	33rd	60.71%	<10th	76.47%	67th	57.89%	<10th	71.43%	33rd	76.92%	67th	52.94%	<10th

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	8/15/2025	**Initiative Name:**	Digital Transformation Strategy	**Start Date:**	2022
Reporting Period:	Apr-Jun (Q4)			**End Date:**	2027
Program Status:	In Progress	**Initiative Owner:**	Yunkyung Kim	**Approved Amount:**	$100.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Digital Transformation Strategy to enhance overall experience for members, providers, and employees by bridging technology and business areas, improving member and provider experience, operational effectiveness, and financial performance.	Provider Lifecycle Management is paused as leadership reassesses the objectives of the project ensuring the scope is aligned to the operational effectiveness of the program. Customer Relations Management (CRM) will be delayed by two months to allow additional time to incorporate real time integration between the product and Facets provider data. All other in-flight Digital Transformation projects are on track: - WebMD Health Hub Oct. 25 - Enterprise Data Masking Mar. 26 - Finance Dynamics 365 Dec 25

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Complete Digital Transformation projects on-time and within budget	95% of projects delivered on-time and within budget	32% (9/28) of total projects have completed within a 5% variance over-all on time and within budget.

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CalOptima Health

Digital Transformation Projects: Status Report

Project Title	Status	Current Annual Budget	Actual Spend
Provider Lifecycle Management (Salesforce)	In Progress	$4,100,000	$1,040,000
Jiva Platform Implementation	Closed	$3,950,000	$1,313,197
WebMD Ignite (FKA Healthwise) Implementation	In Progress	$0	$0
Jiva Findhelp Integration	In Progress	$50,000	$45,000
Content Management for Websites	Closed	$2,457,100	$1,020,938
Contract Center Telephony System Replacement (NICE)	Closed	$2,383,000	$295,482
Call Center CRM (Salesforce)	In Progress	$2,231,250	$0
Finance ERP - Crowe MS Dynamics	In Progress	$1,706,000	$108,000
Enterprise RPA	In Progress	$1,500,000	$1,132,473
HCM & Payroll - ADP Solution	In Progress	$450,000	$18,170
Internet Bandwidth Upgrade for All Sites	Closed	$603,323	$603,323
Network Bandwidth Upgrade for All Sites - Wide Area Network	Closed	$3,631,487	$3,631,487
Cohesity	Closed	$283,489	$283,489
Verisys Credentialing Verification	Closed	$105,000	$105,000
Digital Transformation Strategy (includes Strategic Governance)	Closed	$1,408,060	$1,434,655
SSRS to Power Migration (Phase 1)	Closed	$325,500	$183,300
Member Portal and App	New	$2,000,000	$0
CMS Member Pref. & Consent Mgmt. for Data Sharing	New	$75,000	$0
Web Traffic Analytics for Websites and Portals	New	$50,000	$0
Migration off SecureAuth	New	$56,500	$0
Web Based Services for Facets	New	$250,000	$184,4910
Network Operations Center Monitoring and Control System	New	$300,000	$0
Automate Computer Provision Management Resources with New Infrastructure as a Code (IaC) Technology	New	$185,000	$0
Website Auditing Tool	New	$25,000	$0
Data Strategy, Governance, and Execution	New	$2,975,000	$40,0000
File Encryption	New	$200,000	$0
RightFax Transition to the Cloud	New	$150,000	$21,956
MCG Auto Auth	New	$125,000	$0

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	8/15/2025	**Initiative Name:**	Medi-Cal Provider Rate Increases	**Start Date:**	7/1/2024
Reporting Period:	Apr-Jun (Q4)			**End Date:**	12/31/2026
Program Status:	In Progress	**Initiative Owner:**	Yunkyung Kim	**Approved Amount:**	$526.2 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Authorize the CEO to execute amendments to delegated Health Networks and specific CalOptima Health Medi-Cal FFS CCN/COD contracts that update contracted rates, effective 7/1/2024, and incorporate requirements to comply with DHCS mandated Targeted Rate Increases (TRI) and other regulatory and operational requirements, effective 1/1/2024. This initiative aims to improve quality outcomes through increased access, increased provider and member satisfaction (i.e. CAHPS measures), and decreased provider terminations due to non-market competitive rates.	-Continue to trend provider retention and termination to determine causes. -Continue to work with Health Networks and providers on initiatives to improve access to care and HEDIS measures. -Finalize vendor selection for provider satisfaction survey.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Maintain and increase members' access to care.	Maintain and enhance network adequacy.	Since the rate increase, expanded the network with the addition of: - More than 900 Specialty Physicians into the Medi-Cal network - More than 300 Behavioral Health providers - 3 new FQHCs
	Increase timely access to care for members.	-Contracted with a vendor to provide education and resurvey providers for timely compliance. -MY2025 results not currently available; various interventions are occurring with providers and HNs to improve member satisfaction and timely access to care.
Maintain and increase quality of care for members.	Increase quality scores through the 2024 HEDIS and Quality Scores.	TBD
Improve provider satisfaction.	Increase provider satisfaction scores.	In process for contracting a vendor to develop a provider satisfaction scoring process.

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	8/5/2025	**Initiative Name:**	Skilled Nursing Facility Access Program	**Start Date:**	1/1/2023
Reporting Period:	Apr-Jun (Q4)			**End Date:**	12/31/2026
Program Status:	In Progress	**Initiative Owner:**	Dr. Zeinab Dabbah	**Approved Amount:**	$10.0 Million
Payment Status:	Not Started				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Skilled Nursing Facility (SNF) Access Program is to enhance quality through better access and further strengthen the safety net system across Orange County for individuals who medically complex transitioning from the hospital to home, or from one care setting to another by establishing a dedicated transitional care unit (TCU). The goal of the TCU is to assist in recovery by providing the necessary nursing and rehabilitative care to help members regain independence and facilitate safe discharge.	- Currently in discussion to lease 5-6 beds dedicated to CalOptima Health members within an existing or newly designated TCU space at a KPC facility (or a partner facility) in Orange County.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Improve timely discharge from hospital, including care coordination and continuity.	Reduced extended length of stay (ELOS) by x%	TBD
	Reduced hospital readmission rate by x%	TBD

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Continued to a Future Meeting

CalOptima Health Board Action Agenda Referral

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

Report Item

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

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Javier Sanchez, Executive Director, Medicare Programs, (714) 986-6115

Recommended Actions

Authorize the Chief Executive Officer to implement a policy and procedure to consider requests for letters of support from organizations seeking to offer Program of All-Inclusive Care for the Elderly services in Orange County independently from CalOptima Health.

Background

On October 27, 2017, and on August 17, 2018, the Department of Health Care Services (DHCS) issued a Program of All-Inclusive Care for the Elderly (PACE) policy letters regarding the PACE application process, including guidance on the operation of an independent PACE facility in County Organized Health System (COHS) counties like Orange County. Historically, the only entity that could operate a PACE program in a COHS county was the designated Medi-Cal managed care plan. Welfare & Institutions Code Section 14087.5 et seq. provides that a managed care plan that elects to organize as a COHS holds the exclusive right to contract for Medi-Cal services, including PACE, in the respective county. DHCS policy letters describe a process by which an organization interested in becoming an independent PACE Organization (PO) in a COHS county may, with the formal support of the local COHS plan, be considered by the COHS to operate in that county(s). Specifically, DHCS will only consider an application from an independent PO in Orange County if its application to DHCS includes a letter of support from CalOptima Health. In the letter, CalOptima Health as a COHS plan, must take the significant step of requesting that DHCS submit a formal request to the Centers for Medicare & Medicaid Services (CMS) requesting an amendment to California's existing Section 1115 Medicaid Waiver to make an exception to the existing law that governs COHS plans as part of the independent PO application process. COHS plans, including CalOptima Health, are under no obligation to provide such letters of support.

On September 6, 2018, CalOptima Health's Board of Directors (Board) authorized the Chief Executive Officer (CEO) to establish a process for considering and issuing letters of support to entities seeking to establish a PO independent of CalOptima Health. Since 2018, CalOptima Health has provided letters of support to Alta Med PACE and Innovative Integrated Health PACE, which successfully completed the DHCS and CMS application processes and are currently providing PACE services to many Orange County residents in selected zip codes.

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Discussion
The PACE model has significantly expanded across California. CalOptima Health staff frequently receive inquiries from entities seeking to establish a PO in Orange County. To address these requests, CalOptima Health staff developed Policy PA.9003, PACE Letters of Support, to expand and formalize the process for considering such requests. This new policy will expand on the process previously approved by the Board in 2018, by updating the process for properly and objectively screening applicants according to current PACE industry dynamics, DHCS policy and CMS regulatory requirements.

Fiscal Impact
The recommended action is operational in nature and has no direct fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2025-26 Operating Budget.

Rationale for Recommendation
Approval of PACE Policy PA.9003 will establish a formal process for CalOptima Health staff to process requests and the Board to consider approving letters of support for entities seeking to establish a new PO or to expand the service area of POs currently operating in Orange County.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. DHCS Policy Letter 23-01
2. Draft Policy PA.9003: PACE Letters of Support
3. Prior Board Action dated September 6, 2018, "Consider Approval of Process for Considering Requests for Letters of Support from Organizations Seeking to Offer Program of All-Inclusive Care for the Elderly (PACE) Services in Orange County Independent of CalOptima"
4. Letter of Support

Board Action

Board Meeting Dates	Action	Term	Not to Exceed Amount
April 4, 2019	Authorize Letters of Support for AltaMed Health Services and Innovative Integrated Health, Inc.	N/A	

/s/ Michael Hunn *08/28/2025*
Authorized Signature **Date**

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

Date: April 14, 2023 **Policy Letter 23-01**

Supersedes PACE Policy Letter 19-01

To: Program of All-Inclusive Care for the Elderly Organizations

Subject: Program of All-Inclusive Care for the Elderly Application Process

Purpose

The purpose of this Policy Letter (PL) is to inform Program of All-Inclusive Care for the Elderly (PACE) Organizations (POs) and potential applicant organizations of the Department of Health Care Services' (DHCS) application review process and timeline for new PO applications and PO Expansion applications. This PACE Policy Letter, like all PACE Policy Letters, has the force and effect of state regulation as set forth in Welfare &Institutions Code section 14592(k). DHCS uses the criteria defined in this letter to make a determination to approve, deny or defer an application.

Background

In 2016, the California Legislature passed the PACE Modernization Act Trailer Bill (Sections 31-36 of SB 833, Chapter 30, Statutes of 2016) including updates to the payment and regulatory structure of PACE. The updated California PACE statutes, in part, removed the cap on the number of PO's that could operate in the state, and allowed for-profit entities to become POs.

Centers for Medicare & Medicaid Services (CMS)

The Centers for Medicare & Medicaid Services (CMS) releases annual updates to its PACE Application Guidance to address its electronic PACE application submission timelines, requirements, and review process. Applicants should review this guidance and be aware of CMS requirements for accessing the Health Plan Management System (HPMS). The downloadable PDF of the application and additional information can be found on CMS' website. [1]

State Application Review Process

All new and expansion PACE applications must go through an initial review process by DHCS in order to move forward with submission to CMS via HPMS. The initial submission components provide DHCS with key organizational background and

[1] https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html

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financial viability documentation. This information is necessary for DHCS to complete/sign the State Assurance pages and authorize the submission of the full application to DHCS and CMS via HPMS.

Upon submission of the full application to CMS, DHCS will align its review of the remaining application with the CMS clock cycle, dependent upon the type of application, to create a concurrent review process. Expansion only applications will be on two 45/90 day clock cycles. New PACE center applications will be on two 90 day clock cycles. The initial CMS 45/90-day clock review begins upon receipt of the completed full application in HPMS, which must include the signed State Assurance pages.

DHCS will review the application according to state and federal laws and regulations, contractual requirements, and implementing Policy Letters. Prior to entering into a contract for the provision of Medi-Cal managed health care services, DHCS may consider any factor it determines to be necessary for consideration (Welfare & Institutions Code §§ 14095 and 14592(b)). This includes considering any information relevant to the issue of whether the application could result in unnecessary duplication of services or impair the financial or service viability of an existing program (42 USCA § 1395eee(e)(2)(B)).

DHCS will verify that the applicant is in good standing which includes but is not limited to:

- The applicant and any parties that make up the organization may not be on a Medicaid/Medicare exclusion list.
- Any Medicaid/Medicare line of business operated by the applicant cannot be under sanctions or facing civil monetary penalties from any local, state, or federal government entity.

Applications will not be accepted from existing POs or application entities that currently have some form of Medicaid/Medicare sanction or civil monetary penalty on the entity or parent organization.

If an application entity or parent entity is undergoing a state or federal audit, or is in the process of developing or implementing a Corrective Action Plan, DHCS has the option to delay a final decision on issuance of the State Assurances for any application packet until the conclusion of the audit or Corrective Action Plan of the applying organization or the parent entity if DHCS has significant concerns or findings during those audits. If an audit results in significant findings supporting sanctions or civil monetary penalties, the state will require the PO to withdraw the application and will not allow re-submission until the findings and/or sanctions have been resolved through a corrective action plan as has been identified in the audit process.

Initial State Review

All new and expansion applications received by DHCS will follow the below initial state review timeframes for application submission:

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Action	Due Date	Documents for *PO* Submission	Reviewer	Review Timeframe
Applicant Notification of Intent to DHCS	30 days prior to Initial Application Submission to DHCS	• Letter of Intent • Letter for Support from COHS (if applicable) • Address of new PACE center Estimated operational date (subject to DHCS approval)	DHCS	30 calendar days
Initial Application Submission to DHCS	90 days prior to CMS application submission deadline	• Market Feasibility Study • Letters of Support • Application sections (see Attachment III) • Address of PACE center	DHCS	90 Calendar Days
Full Application Submission in HPMS	Align with CMS PACE Application Submission Deadline	• Remaining application sections • State Assurance (Attestation) Page	DHCS & CMS	Align with CMS 45/90 day review clock

If DHCS defers the decision on an application for two consecutive quarters due to the applicant not meeting the requirements of this Policy Letter and all applicable state and federal requirements, DHCS will deny the applicant. If an applicant has been denied DHCS will not accept a new or expansion application submission for a period of two quarters.

Concurrent Federal and State Review

The CMS review process of the PACE Application will include a series of attestations and uploads based on the type of application received (Initial Application or Service Area Expansion SAE)). Please see Attachment I (PACE Application Required Attestations and Uploads). DHCS will sign the attestation pages and release to applicant along with the state appendices, M, N, P, Q, R, and S. The applicant will then submit the signed attestation and state appendices to CMS by the quarterly submission deadlines.

During the initial CMS 45/90-day clock review of the full application, CMS and/or DHCS may issue a Request for Additional Information (RAI) to the applicant. In the event a RAI is issued, the application is taken off the review clock while the applicant responds to the RAI. DHCS will align its remaining review and RAI (if necessary) with CMS timelines and ensure that any necessary changes are communicated to CMS.

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It is also during this period that DHCS conducts the State Readiness Review (SRR) onsite survey of the applicant PACE Center, as required. All initial applications, and any SAE application that includes the addition of a new PACE center, require an SRR of the new center. All deficiencies identified during the DHCS SRR onsite survey of the applicant PACE Center must be addressed through a corrective action plan submitted to and accepted by DHCS. The applicant must revise the corrective action plan per DHCS request, until DHCS approves it to move forward. The application will not be moved forward until the applicant successfully completes the DHCS approved corrective action plan.

Once CMS and/or DHCS have accepted the applicant's RAI response, and the SRR onsite survey has been satisfactorily completed by DHCS and accepted by CMS, CMS will reinitiate the final 45/90-day clock review cycle. Conclusion of this cycle results in CMS notification to the applicant of final approval or denial. The application will be denied if any of the criteria set forth in this letter are not met or addressed through the RAI process.

PACE Growth and Expansion

All PACE growth and expansion falls into one of the below categories:

1. New PACE Organization – A new entity applying to establish a PO
    - An entity must identify specific zip codes to be served in one or more counties.
    - An entity must identify zip codes that overlap with any existing operational POs and potential POs with pending applications. Information on obtaining information regarding existing and potential POs is set forth below.
    - An entity must be able to serve all requested zip codes from the PACE Center (subject to the 60-minute one-way drive time to and from the participants' homes to the adult day health center (ADHC)).
    - Rate development is required for each county requested, refer to "Program Start Date" section below.
2. Existing PO Expansion (Existing County) – PO's adding additional zip codes within the existing county service area, opening a new PACE Center within the existing county service area, or both
    - An entity must be able to serve all requested zip codes from the PACE Center(s) subject to the 60-minute one-way drive time to and from the participants' homes to the ADHC requirement, as specified below.
    - An entity must identify zip codes that overlap with any existing operational POs and potential POs with pending applications. Information on obtaining information regarding existing and potential POs is set forth below.
    - POs can add zip codes and use Alternative Care Settings (ACS) as an interim step before building new PACE Center.

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  - For ACS requests, refer to CMS Guidance Memorandum "Alternative Care Settings in the PACE Program".
- DHCS and its actuaries must analyze the requested expansion for potential rate impact. If a rate impact is identified (requiring new rate development), the request will be treated in accordance with the program start dates outlined below.
- Zip code only expansions are subject to a shorter CMS review period.

3. Existing PO Expansion (New County) – PO adding zip codes in a new county of operation

   - Usually requires a new PACE Center unless the zip codes requested fall within the required radius to be served by the existing PACE Center and interdisciplinary team (IDT).
   - An entity must identify zip codes that overlap with any existing operational POs and potential POs with pending applications. Refer to the "PACE Expansions Proposals" document posted on a monthly basis on the DHCS PACE website.[2]
   - Rate development is required for each new county requested and are subject to the January and July program start dates detailed below.

Program Start Date

To align with DHCS budget and rate development processes, all new and existing PO expansion applications requiring new rate development may only be able to begin operations on either January 1 or, July 1, of a given year in accordance with the timeline below.

Applications submitted to CMS in the quarterly windows from January through June of a given calendar year may begin operations no sooner than July 1 of the subsequent calendar year, pending final DHCS and CMS approval of the new PACE Organization or Existing PO Expansion application.

Applications submitted to CMS in the quarterly windows from July through December of a given calendar year may begin operations no sooner than January 1 of the calendar year that follows the subsequent calendar year (i.e., a December 31, 2022 submission would be eligible for a January 1, 2024 start date), pending final DHCS and CMS approval of the new PO or SAE application.

Prospective POs and expansion applicants requiring new rate development should consider the available start dates when preparing to submit an application. Any delays in the application submission or review process may result in the program start date getting pushed back to the next available program start date of either January 1 or July 1.

[2] Program of All-Inclusive Care for the Elderly ("PACE Expansions Proposals" Link)

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Applicants should also account for the time frame requirements of other public licensing entities (e.g., California Department of Public Health) when considering the overall application timeline process.

All new POs, and existing POs in new Counties, must initiate marketing activities immediately upon the approval of the three-way program agreement and must begin processing enrollments immediately following the go-live date.

Letter of Intent Submission Components

Thirty days prior to submitting an initial application to DHCS, all applicants must submit to DHCS a Letter of Intent (LOI) indicating their plans to submit a PACE application. The LOI must identify and/or include the following:

- The applicant;
- The proposed service area, including a listing of proposed zip codes and a service area map with:
  - The location of the PACE center clearly marked;
  - A scale of the complete geographic service area that includes county, zip code, street boundaries, census tract or block or tribal jurisdiction, main traffic arteries, physical barriers such as mountains and rivers, hospital providers, ambulatory and institutional services sites;
  - The drive time from the farthest points on the geographic boundaries to the PACE Center, Including allowances for traffic as well as assistance time and multiple participants. The PO needs to be able to effectively serve the entire proposed service area in the first year of operation; and
  - The drive time to the nearest ambulatory and institutional service sites.
- If the geographic service area includes an area covered by another PACE organization, provide a list of overlapping zip codes as well as identifying all overlap areas in the service area map;
- Letter of support from COHS, as described below;
- The address for the applicant's PACE center,[3] and
- The anticipated operational date of the center (subject to DHCS approval) based on DHCS program start date guidelines above.

If an applicant wishes to withdraw their LOI an email must be sent to the DHCS team which confirmed receipt of the LOI and is reviewing the application. The withdrawal email must include details behind the circumstances that led to the withdrawal and whether they plan on submitting a new LOI in a future quarter.

All applicants proposing to serve an area with an existing or pending PACE plan must identify the overlapping zip codes in their LOI. If an applicant has any questions about whether there is an existing or pending PO operating in its proposed service area it can

[3] *NOTE: Once the initial application has been submitted to CMS, the PACE Center address cannot be changed. If the PACE Center address changes, the applicant will need to withdraw their initial application with CMS and DHCS and the application process will start over, requiring the submission of a new LOI.*

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refer to the DHCS PACE website[4] for a listing of all zip codes by county that PO's currently operate in. Pending applications for new or expansion PO's are also posted to the DHCS website.[5]

CMS application submission deadlines can be found under the application training guide on CMS' website.[6]

The LOI to DHCS must be submitted at least 120 days prior to the proposed CMS submission date, and the initial application must be submitted at least 90 days prior to the proposed CMS submission date. Applications submitted to DHCS after these dates will not be accepted and will need to be resubmitted for a subsequent CMS quarterly submission date cycle.

Initial Application Submission Components

Letters of Support

All PACE applicants must submit letters of support from local entities or individuals in the area that the applicant proposes to serve. The purpose of these letters is to demonstrate that the applicant is connecting with local entities who will work closely with the incoming PO and provide community support. These may include but are not limited to: political representatives, County Board of Supervisors, County Health and Human Services (HHS) Director, local hospitals, Medi-Cal managed care health plans (MCPs), Independent Physician Associations (IPAs), Commission on Aging, Area Agencies on Aging (AAA), and Community Based Organizations (CBOs). Letters of support should be attached to the initial application.

At a minimum, applicants must submit:

- three (3) letters of support from local government agencies or political representatives,
- three (3) letters of support from local health care providers operating in the proposed service area, and
- three (3) letters of support from CBOs (colleges, churches, social service groups, etc).

DHCS reviews letters of support and may reject a letter based on the following criteria:

- The entity writing the letter of support does not operate within or represent the requested service area.
- The entity writing the letter of support has a financial interest in or has been engaged by the applicant for consulting purposes.

[4] http://www.dhcs.ca.gov/individuals/Pages/PACEPlans.aspx
[5] https://www.dhcs.ca.gov/services/ltc/Pages/programofall-inclusivecarefortheelderly.aspx
[6] https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html

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For PACE applicants wishing to serve in COHS and Single Plan Model Counties, refer to the "POs in County Organized Health System and Single Plan County Model Counties" section later in this letter.

Market Feasibility Study

All PACE applicants, including SAEs, must submit to DHCS a market feasibility study of the area that they propose to serve. The feasibility study must include the following:

- Estimate of the number of PACE-eligible individuals
- Description of the methodology/assumptions used to determine potential membership
- Identify all competitive factors impacting the market, such as:
  - Existing PO's
  - Medi-Cal MCPs
  - Demonstration County MCPs (Cal MediConnect and Managed Long-Term Services and Supports (LTSS))
  - Dual Special Needs Plans (D-SNPs)
  - Medi-Cal Waiver Programs
  - In-Home Supportive Services (IHSS)
- Identify projected market capture/saturation rates
- Demonstrate that there is an unmet need for PACE in the proposed service area
  - Please note that when multiple applications are received for the same county/zip code service area the order of submission and number of pre-existing plans may have an impact on the decision to approve/deny an application.

State Application Narrative

The following PACE application sections must be submitted to DHCS for initial review (see Attachment III): Please refer to DHCS website "PACE Orientation Package & Approved Templates" for resource and templates.

New PACE Application	**Service Area Expansion (Existing and New County)**
• 3.1 – Service Area • 3.2 – Legal Entity and Organization Structure • 3.3 – Governing Body • 3.4 – Fiscal Soundness • 3.5 – Marketing • 3.13 – Contracted Services • 3.23 – Transportation Services	• 3.1 – Service Area • 3.4 – Fiscal Soundness • 3.5 – Marketing • 3.13 – Contracted Services • 3.23 – Transportation Services

In addition to the attestations and documents required in the PACE application, the applicant must provide DHCS a detailed narrative covering each of these sections to

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demonstrate to DHCS the organizational background and financial standing of the applicant. Applicants should refer to the Attachments in this document as well as the documents on the DHCS PACE website under PACE Orientation Package & Approved Templates.[7]

Financial Documentation

The applicant must demonstrate evidence of sufficient capital and/or capital funding to finance the PACE entity or expansion through the projected breakeven point, while maintaining sufficient reserves as required by 42 CFR § 460.80 - Fiscal soundness and the application process. In demonstrating this, DHCS also requires that the documentation must show that the applicant's assets are greater than the unsubordinated liabilities, including when the applicant is applying for funding. Applicants must clearly document all funding being utilized for this application, including documentation of the source of funding and documentation of any agreements related to the funding. The proforma documents submitted by the applicant must contain reasonable assumptions for projected PACE cost and revenue from start up to the breakeven point.

Additional Considerations and Limitations

60 Minute Drive Time Analysis

The applicant is responsible for developing the initial 60-minute drive time analysis for each zip code identified in the initial application. Applicants must use the farthest points in the geographic boundaries to the PACE center. Applicants must take into consideration and incorporate time measures when multiple participants are being transported at the same time, while ensuring safety and all participant needs are being met. Applicants must also consider high traffic times in highly populated urban areas. The applicant must use commute hours of 6:00am to 8:00am and 2:00pm to 4:00pm. DHCS will review the initial analysis and conduct their own review. DHCS will identify a landmark at random in the farthest point of the zip code and calculate the drive to and from that landmark. DHCS calculates the drive using multiple traffic patterns throughout the day. If DHCS determines a zip code does not meet the drive time requirements, while taking into consideration all the factors listed above, the applicant will be required to remove the zip code from their application. DHCS will be unable to move forward with an application in which an applicant has refused to remove the request zip codes.

Multiple Initial Applications at Once

DHCS will not permit sponsoring or parent organizations applying to become a PACE Organization to submit a new initial application requiring a new "H" number until the current PACE Organizations under their scope have demonstrated their success in operating a PACE program and have passed their first trial period audit.

[7] https://www.dhcs.ca.gov/services/ltc/Pages/Templates.aspx

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Applying parent organizations with pending multiple initial applications while this new requirement was being developed will be grandfathered in and their pending applications will not be impacted.

Overlapping service area

New applicants proposing to enter an area already served by an existing PO must identify the overlapping zip codes in their LOI. DHCS will immediately notify by email any existing and/or pending POs of the new applicant's intent, and the existing and/or pending POs will have an opportunity to submit their own market feasibility study in response. The counter-feasibility study must be submitted to DHCS within 30 days of the existing and/or pending PO receiving the email notification from DHCS. Overlapping service areas are determined at the zip code level. Therefore, if a PO is only servicing a portion of a county, and a new or expansion application is requesting a zip code not in the PO's service area, by zip code, then the new or expansion application would not trigger notification to the existing/pending PO for an overlapping service area competing market feasibility study.

DHCS will conduct its own market feasibility study using Medi-Cal data to verify the market feasibility studies that applicants/POs submit. DHCS will evaluate actual numbers of Medi-Cal beneficiaries by age and aid code and will use historical trends of clinical eligibility and market capture to compare against market analyses submitted by applicants/existing PO's.

Letters of Opposition

DHCS will acknowledge receipt of any letters of opposition submitted as part of the counter analysis process. DHCS does not place significant weight on letters of opposition, however all letters will be documented and taken into consideration.

Restrictions on Delegation

This PACE Policy Letter clarifies the PACE delegation restrictions set forth in previous DHCS PACE Policy Letters. DHCS prohibits existing and applicant POs from delegating or subcontracting the operation and staffing of existing and/or additional (expansion) PACE Centers and IDTs to a separate entity.

POs are responsible for coordinating and delivering the medical and long-term care of frail and vulnerable elderly Californians so that they can remain living safely in their community rather than receiving institutional care. Because of the complexity of this responsibility, the Department prohibits any arrangements to delegate the administration of a PACE Center or PACE IDT to third parties. These DHCS concerns regarding delegation in the PACE model are reflected in the Responses of CMS to Comments presented in the Federal Register, Volume 71, No. 236, pages 71247 to 71263, and 71270 to 71272, regarding Title 42, Code of Federal Regulations, parts 460.60, 460.70, and 460.71.

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There is one existing delegated delivery model within PACE in California. The On Lok delegation contract with the Institute of Aging was originally established on August 1, 1996. This model was identified as a contractual arrangement in place on or before July 1, 2000 and was confirmed as "grandfathered" in by CMS in a January 15, 2002, letter. Grandfathering was necessary as the arrangement was not explicitly allowed under the PACE permanent provider regulations at that time.

While DHCS explicitly prohibits full delegation of the fundamental program elements of operation of the PACE Center and IDT, POs have the ability to subcontract for any service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a participant in their home/community are accessible by the PO. POs may enter into subcontracting agreements using the PACE Subcontract Boilerplate template provided by DHCS. Any amendments to the boilerplate template require the Department's prior written approval.

All approved subcontracts need to be in place with signed contract agreements prior to the scheduled go-live date. Pending subcontracts must have the approval for extension granted by DHCS to be signed no later than 1 month after the go live date.

Please note that DHCS' prohibition on the use of delegation in PACE does not impact POs option to utilize alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the participant's home, an inpatient facility, or PACE Center. A PACE participant receives some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center and all PACE participants receiving services at an ACS must be assigned to a PACE Center and IDT.

POs in County Organized Health System and Single Plan Model Counties

Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county. Specifically, Welfare & Institutions code 14087.5 et seq. provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services in those counties. DHCS will only consider the operation of a third-party PO in a COHS county if the applicant includes a letter of support from the COHS that includes a statement from the COHS that the COHS supports the establishment of the independent PO in the county, and verification of the COHS' concurrence with the applicant's proposed service area. The COHS letter of support must be signed by the COHS' Chief Executive Officer, Chief Financial Officer, or the Chief Operational Officer.

The COHS letter of support must be included with the LOI submitted by the applicant organization signifying its intent to expand into a COHS county or to start a new PO in a COHS county. A separate letter of support from the County Board of Supervisors is not required. Based on the provided information, DHCS will decide whether to move forward with a non COHS PACE application in a COHS county. If DHCS approves operation of a non COHS PO in a COHS county, the non COHS PO must contract

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directly with DHCS and CMS as the PACE entity in the three-way program agreement. DHCS will not allow a COHS to contract with DHCS and CMS as the PACE entity in the three-way program agreement and then delegate operation of the PO to a separate entity.

The same rules apply to Single Plan Model Counties.

Licensing

With the implementation of AB 1128, primary care clinics, home health agencies, and adult day health centers (whether or not they are operated by a PO) that are providing services solely to PACE participants fall under the oversight and regulation authority of DHCS (W&I 14592(c)). POs should refer to the DHCS Policy Letter "DHCS Approval Process for Operating Primary Care Clinics, Adult Day Health Care centers, and Home Health Agencies under AB-1128" for details on the DHCS authority requirements under the AB 1128 process.

Primary care clinics, home health agencies, and adult day health centers (whether or not they are operated by a PO) that are providing services to a mixed population are subject to the authority of the California Department of Public Health (CDPH) licensing process.

PACE Centers must maintain a Primary Care Clinic (PCC) License and an Adult Day Health Center (ADHC) License. PO's must also choose to either maintain a Home Health Agency (HHA) License or contract with a licensed HHA for home health services. Health & Safety Code section 100315 allows DHCS, CDPH, the California Department of Social Services and the California Department of Aging to authorize exemptions to a PO from specific licensing requirements for clinics, ADHC centers, Community Care Licensing facilities, and HHAs that are duplicative, conflicting, or inconsistent with PO requirements. Applicants should consult with the appropriate licensing entity to verify licensing requirements and anticipated timelines.

For-profit entities applying to become a PO do not qualify to be licensed as a PCC as defined under H&S Code section 1204, Such a PO's PCC must comply with the standards set forth in Welfare & Institutions Code section 14592(c), and are subject to oversight and regulation by DHCS.

For POs that fall under the DHCS authority, the onsite and desk review of PCC, ADHC, and HHA standards will occur concurrently with the SRR of the PACE center. CMS will not accept the SRR until all required licenses are secured.

CDPH Licensure applications can be found on the CDPH website.[8]

[8] https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/ApplyForLicensure.aspx

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Replacement PACE Centers

Existing PO's may move locations or consolidate PACE Center sites by constructing a replacement PACE Center. This scenario is distinct from the construction of a new PACE Center, which requires the submission of a Service Area Expansion application. Replacement Centers require the following transition planning items:

- Administrative Notifications: Notify CMS and DHCS at least 120 days prior to projected transition date.
- Transition Plan: PO's must submit a detailed transition plan that outlines the occupancy timeline, replacement center capacity, contingency planning, transportation plan, notification to participants, and details of any changes in staffing, policies and procedures, etc.

A PO seeking to replace its PACE Center(s) should refer to CMS guidance released on October 21, 2016 that provides further detail on the requirements for transition. Replacement Centers are not subject to the January 1 or July 1 start dates.

The new application process policies within this updated PL will become effective on the quarter following the final release of this PL.

If you have any questions regarding the requirements of this Policy Letter, please contact your Integrated Systems of Care, PACE Contract Manager.

Sincerely,

DocuSigned by:
Cortney Maslyn
30016FCE843D430...
Cortney Maslyn, Chief
Integrated Systems of Care Division
Department of Health Care Services

Enclosures

Attachment I
Attachment II
Attachment III

Policy:	PA.9003
Title:	**PACE Letters of Support**
Department:	CalOptima Health PACE
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☒ PACE

For 20250904 BOD Review Only

I. PURPOSE

This policy defines the process for organizations to request a letter of support from CalOptima Health as required to apply to the Department of Health Care Services (DHCS) to establish a new third-party Program of All-Inclusive Care for the Elderly (PACE) Organization (PO) independent of CalOptima Health's PACE program, or to expand an existing PO's service area in Orange County.

II. POLICY

A. As a County Organized Health System (COHS), CalOptima Health is the sole source for Medi-Cal services in Orange County. Welfare & Institutions Code (WIC) Section14087.5 et seq. provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services, including PACE. Department of Health Care Services (DHCS) Policy Letter (PL) 23-01: Program of All-Inclusive Care for the Elderly Application Process requires entities submitting applications to establish a new PO or expand an existing PO's service area in COHS counties like Orange County to submit a letter of support from CalOptima Health in their application.

B. DHCS policy requires that letters of support from COHS plans must include a statement of explicit support for the establishment of the independent PO, and verification of concurrence with the applicant's proposed service area.

C. Entities that submit a request are not guaranteed a letter of support from CalOptima Health. CalOptima Health reserves the right to deny any request from an entity seeking to establish a new PO or expand service area at its sole and absolute discretion. Nothing in this policy is intended to indicate the entity requesting a letter of support is guaranteed to be approved.

D. A prospective PO must submit a formal request for a letter of support, complete an application, and meet all the criteria included in the Procedure section of this policy for CalOptima Health to consider the request.

E. CalOptima Health will not accept requests from entities proposing to establish a new PO that covers a service area that includes all zip codes in Orange County.

F. CalOptima Health will only consider requests for a letter of support from entities that are organized as non-profit entities and are wholly owned and controlled by a non-profit parent entity.

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G. CalOptima Health will verify that the applicant is in good standing which includes but is not limited to:

1. The applicant and any parties that make up the proposed PO, the parent entity, any affiliated entities under common ownership or otherwise related to the proposed PO may not be on a Medicaid/Medicare exclusion list, as outlined in CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring.

2. Any Medicaid/Medicare line of business operated by the applicant or affiliated entities cannot be under sanctions or facing civil monetary penalties from any local, state, or federal government entity.

H. Letters of support are subject to approval by the CalOptima Health Board of Directors, which must be submitted directly to DHCS and will be signed by CalOptima Health's Chief Executive Officer (CEO), the Chief Operating Officer (COO), or the Chief Financial Officer (CFO).

I. Letters of support provided by CalOptima Health to new independent POs are not intended to create nor shall they be deemed or construed to create any relationship between the new independent PO and CalOptima Health, or CalOptima Health's PACE organization.

III. PROCEDURE

A. Submission and Review of Formal Requests for Letter of Support Requests and Required Applications and Documents

1. Entities seeking letters of support from CalOptima Health must submit a formal written request to CalOptima Health's Chief Executive Officer via email or other written form signed and dated by the requesting Chief Executive Officer, or designee, with the authority to make decisions on behalf of the applicant entity that is establishing the proposed PO or expanding an existing PO.

2. Formal written requests must specifically state the nature of the request and include specific information applicable to the request.

a. When requesting a letter of support for an application to DHCS to establish a new PO in Orange County, the requesting entity must submit the following information in their formal written request:

i. Identify the specific zip codes planned to be served.

ii. Identify the zip codes that overlap with any existing POs and potential POs with pending applications.

iii. A transportation plan that demonstrates the proposed PO's ability to serve all requested zip codes from the PACE center location(s) to and from the prospective Participants' home in less than 60-minute per one-way drive.

b. When requesting a letter of support for an application to DHCS to expand an existing PO's service area, the requesting entity must submit the following information in their formal written request:

i. Identify specific expansion zip codes;

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ii. Identify zip codes that overlap with any other existing operational POs and potential POs with pending applications; and

iii. A transportation plan that demonstrates the proposed PO's ability to serve all requested zip codes from the PACE center location(s) to and from the prospective Participants' home in less than 60-minute per one-way drive.

3. CalOptima Health's Executive Director of Medicare Programs shall review the request within fifteen (15) business days of receipt of the request and present a recommendation to CalOptima Health Executive leaders.

B. If CalOptima Health leaders determine that the initial request meets the Board of Director's strategic objectives for serving Orange County PACE eligible residents, the Executive Director of Medicare Programs will send a written response informing the entity requesting a letter of support of CalOptima Health's decision.

1. If the request is approved, the applicant will be informed of the requirements to move forward with the application process.

2. If the request is denied, the Executive Director of Medicare Programs will respond to explain the specific reason for the denial.

C. Application and Documentation

1. Entities requesting a letter of support from CalOptima Health must complete an application that shall include the following elements and supporting documentation.

a. Primary Criteria (50% weighting)

i. Potential impact on CalOptima Health PACE operations and other POs operating in Orange County.

ii. Evaluation of overlap with existing POs in the Orange County (e.g., also considering likelihood of adverse member selection, member confusion, geographic separation, etc.).

iii. Evaluation of prospective PO's application demonstrates that they are proposing to offer complementary services to existing POs in Orange County including but not limited to:

a) Services to unique member populations, serving remote or underserved geographic areas of Orange County;

b) Bringing new Providers into the PACE system; or

c) Other meaningful ways of expanding or enhancing services to Orange County PACE eligible beneficiaries.

b. Threshold Criteria (50% weighting): All letters of support applications shall include and will be evaluated based on the following criteria:

i. PACE Operating Experience:

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a) Must demonstrate a minimum of five (5) years of operating experience in California;

b) Provide documentation of DHCS or Centers for Medicare & Medicaid Services (CMS) regulatory audits with no sanctions;

c) Submit PACE operational policies and procedures; and

d) Obtain reference letters from member advocates, providers and community stakeholders unaffiliated or who have no financial interest in the entity applying for a letter of support.

ii. Financial Soundness:

a) Submit financial statements (income statements and balance sheets) for the three (3) most recent consecutive years;

b) Report on financial metrics (i.e., liquidity, debt ratio, short-term viability, delinquency); and

c) Obtain third-party risk report via Dunn and Bradstreet (where available).

iii. Quality Performance/Metrics:

a) Report on performance against current CalPACE averages in areas of Participants residing in nursing homes, hospital admissions, hospital days, hospital readmission rate, emergency room visits and Participant satisfaction rating;

b) Results of their most recent Integrated Satisfaction Measurement for PACE (I-SAT) survey;

c) Latest DCHS and CMS audit report and findings;

d) Current Fiscal year report on number of Grievances by type; and

e) PACE Annual quality metrics.

iv. Demographic Competence:

a) Provide a general PACE demographic profile data of the ZIP code area of interest.

b) Demonstrate experience and qualifications of staff serving PACE participants in the potential geographic area including:

1) Training in cultural competency;

2) Language capability;

3) Accommodation for low literacy; and

4) Response to socioeconomic factors.

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D. Initial Review

1. Upon verifying the requesting entity is not excluded or precluded from participating in a federally-funded healthcare program, the prospective request for a letter of support will be reviewed.

2. If the documentation does not meet the requirements, the CalOptima Health Executive Director of Medicare Programs shall notify the applicant of the deficiency and denial of application.

E. CalOptima Health Review Team

1. If the entity requesting a letter of support meets the requirements and all required documentation is received, the Executive Director of Medicare Programs shall forward the prospective PO application packet to the CalOptima Health review team. The team will review and score the documents in accordance with the instructions on the scoring tool. The CalOptima Health review team will review and tally the scores and will make a recommendation.

2. If the review team determines that the applicant is eligible for a letter of support, CalOptima Health's Executive Director of Medicare Programs shall present the findings to CalOptima Health's Executives.

3. Executive leaders will present a recommendation as a CalOptima Health Board Action Referral (COBAR) to the CalOptima Health Board of Directors for approval. The Board of Directors may approve or deny the request.

F. If the Board of Directors approves issuing a letter of support on behalf of the requesting organization, the Executive Director of Medicare Programs will draft a letter for the CEO, COO or CFO to sign, submit directly to DHCS, and provide a copy to the applicant for their Letter of Intent (LOI) submission to DHCS.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Welfare & Institutions Code (WIC), Section 14087.5
B. Department of Health Care Services (DHCS) Policy Letter (PL) 23-01: Program of All-Inclusive Care for the Elderly Application Process
C. CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

For 20250904 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Effective		PA.9003	PACE Letters of Support	PACE

1

For 20250904 BOD Review Only

IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
County Organized Health System (COHS)	Medi-Cal health plan that is run by a county government entity and is the sole Medi-Cal heath plan operation in the county without enrollment limits
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program.
Grievance	A complaint, either oral or written, expressing dissatisfaction with service delivery or the quality of care furnished, regardless of whether remedial action is requested as defined by the federal PACE regulation 42 CFR Section 460.120.
Participant	An individual enrolled in the CalOptima Health PACE program.
Program of All-Inclusive Care for the Elderly (PACE)	PACE is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.

For 20250904 BOD Review Only

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Approval of Process for Considering Requests for Letters of Support from Organizations Seeking to Offer Program of All-Inclusive Care for the Elderly (PACE) Services in Orange County Independent of CalOptima

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Action

Authorize the CEO to implement a process to consider requests for letters of support from organizations seeking to offer PACE services in Orange County independent of CalOptima, with all final decisions subject to Board approval.

Background

PACE is a comprehensive health care program that CalOptima provides for frail seniors in Orange County. The PACE model is a person-centered, community-based alternative to nursing home care. PACE supports elders and their families by providing preventive and primary care, and coordinating behavioral health and acute care, as well as long-term services and supports. The intensive care coordination helps individuals with complex chronic care needs to continue living in the community as long as possible. CalOptima opened Orange County's first PACE center in October 2013, and the program has grown to nearly 300 participants. CalOptima recently launched several new initiatives designed to expand access to PACE, including partnerships with Community-Based Adult Services (CBAS) centers, a greater role for community-based physicians in caring for PACE participants, and a larger PACE service area to reach all eligible seniors in Orange County.

On October 27, 2017, and on August 17, 2018, the Department of Health Care Services (DHCS) issued PACE policy letters regarding the PACE application process, including guidance on operation of an independent PACE facility in County Organized Health System (COHS) counties including Orange County. Historically, the only entity that could operate a PACE program in a COHS county was the designated Medi-Cal managed care plan. Welfare & Institutions code section 14087.5 *et seq*. provides that a managed care plan that elects to organize as a COHS holds the exclusive right to contract for Medi-Cal services, including PACE, in the respective county.

However, the above-referenced DHCS policy letters describe a process by which an organization interested in becoming an independent PACE Organization (PO) in a COHS county may, with the formal support of the local COHS plan, be considered to operate in that county(s). Specifically, DHCS will only consider an application from an independent PO in a COHS county if its application to DHCS includes a letter of support from the COHS Medi-Cal managed care plan. In the letter, the COHS plan must take the significant step of requesting that DHCS submit a formal request to the federal Centers for Medicare & Medicaid Services (CMS) requesting an amendment to California's existing Section 1115 Medicaid Waiver as part of the independent PO application process to make an exception to the existing

law that governs COHS plans. COHS plans, including CalOptima, are under no obligation to provide such letters of support.

Specific to the application process for organizations seeking to operate in COHS counties, the COHS plans' only role is to issue (or not issue) a letter of support. If the COHS plan does not issue a letter of support, DHCS will not approve the application; if the COHS does provide a letter of support, it will be up to state and federal regulators to make all subsequent decisions on the application.

Since the release of the DHCS policy letters, staff has received informal inquiries from groups interested in applying to become independent POs in Orange County on how and whether CalOptima intends to respond to any requests for letters of support requesting that DHCS seek formal modification of California law governing the COHS framework.

Should CalOptima decide to provide one or more letters of support to independent POs, the decision would then be out of CalOptima's hands, and the independent POs would follow an application process first involving DHCS, and if DHCS submits the request, CMS would consider whether to approve the requested waiver amendment. If CMS approves the waiver amendment, DHCS would then evaluate the independent PO application, and if approved, the application would go to CMS for final approval.

Separate from considering requests from independent POs, CalOptima staff is continuing Board-approved expansion efforts through collaboration with community partners. These include expanding CBAS center use through Alternative Care Setting sites, continuing to cultivate referrals from contracted community-based physicians, enrollment efforts in South Orange County, increasing current sales and marketing efforts, adding a Veteran's Choice option to encourage enrollment by veterans, and adding a Medicare-only members option.

Discussion

In response to the DHCS policy letters and independent PO inquiries, staff is recommending that the Board approve an internal review process for the evaluation of requests for letters of support from organizations seeking to establish independent PACE operations in Orange County and making recommendations to the Board.

Elements of the process to consider letter of support requests include, but are not limited to:

1. **Application timeline window:** Subject to Board approval, staff anticipates accepting letters of support requests beginning November 1, 2018, to January 31, 2019.
2. **Geographic ZIP code designation:** Consistent with the DHCS and CMS PACE organization application process and policy, independent PO letter of support requests will include the specific ZIP codes the independent PO is interested in serving.
3. **Threshold Criteria (~~20~~50% weighting):** All letter of support requests from independent POs shall include and will be evaluated based on the following criteria:
    a. PACE operating experience
        i. Show a minimum of five (5) years of operating experience
        ii. Provide proof of regulatory audits with no sanctions

Rev. 9/6/18

iii. Submit operational policies and procedures
iv. Obtain reference letters from member advocates, providers and community stakeholders

b. Financial soundness
   i. Submit financial statements (income statements and balance sheets) for the three most recent consecutive years
   ii. Report financial metrics (i.e. liquidity, debt ratio, short-term viability, delinquency)
   iii. Obtain third-party risk report via Dunn and Bradstreet (where available)

c. Quality performance/metrics
   i. Report performance against current CalPACE averages in areas of participants residing in nursing homes, hospital admissions, hospital days, hospital readmission rate, emergency room visits and participant satisfaction rating

d. Demographic competence
   i. Provide a general PACE demographic profile data of the ZIP code area of interest
   ii. Demonstrate staff experience and/or understanding in serving PACE participants similar to those in the potential geographic area
      1. Training in cultural competency
      2. Language capability
      3. Accommodations for low literacy
      4. Response to socioeconomic factors

4. **Primary Criteria (~~80~~ 50% weighting):** Potential impact on CalOptima PACE program/operations and other POs operating in Orange County, if any. Rev. 9/6/18
   a. For POs with strong demonstrated performance on the Threshold Criteria, the focus would be on, for example, evaluation overlap with existing PACE facilities in the County (e.g., also considering likelihood of adverse member selection, geographic separation, etc.); how the PO's application demonstrates that they are proposing to offer complementary PACE services (e.g., for unique member populations, serving remote/underserved geographic areas of the County, bringing new providers, or in some other meaningful ways, enhancing existing PACE facilities).

5. **Return to the Board with Recommendations**. After analyzing PO proposals and requests for letters of support, staff will return to the Board with recommendations.

Fiscal Impact

The recommended action is projected to be budget neutral. CalOptima's Fiscal Year 2018–19 Operating Budget, approved by the Board on June 7, 2018, included projected revenues and expenses related to the continuation of PACE expansion.

Staff anticipates that the administrative expenses included in the Board-approved operating budget are sufficient to cover the anticipated costs related to the recommended action.

Rationale for Recommendation

Staff recommends that the Board adopt a process for considering requests for letters of support from organizations seeking to offer PACE services in Orange County independent of CalOptima. As a public agency, CalOptima should be prepared to respond to such potential requests.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS PACE Policy Letter 17-03, issued on October 27, 2017.
2. DHCS PACE Policy Letter 18-01, issued on August 17, 2018.
3. Presentation: PACE Response to Regulatory Guidance

/s/ Michael Schrader — *8/29/2018*

Authorized Signature — **Date**

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Date: October 27, 2017

Policy Letter 17-03
Replacing PACE Policy Letter 16-01

To: Program for All-Inclusive Care for the Elderly (PACE) Organizations

Subject: PACE Application Process

Purpose

The purpose of this Policy Letter is to inform Program of All-Inclusive Care for the Elderly (PACE) Organizations (POs) and potential applicant organizations of the revised Department of Health Care Services (DHCS) application review process and timeline for new PO applications and PACE Expansion applications.

Background

In 2016, the California Legislature passed the PACE Modernization Act Trailer Bill (Sections 31-36 of SB 833, Chapter 30, Statutes of 2016) including updates to the payment and regulatory structure of PACE. The updated California PACE statutes, in part, removed the cap on the number of POs that could operate in the state, and allowed for-profit entities to become POs. As a result, DHCS has seen renewed interest in PACE and an increase in new/expansion applications submitted to DHCS for review. Therefore, DHCS is issuing revised guidance to clarify the Department's expectations with respect to the competitive nature of the review process.

The Centers for Medicare & Medicaid Services (CMS) released the 2017 PACE Application Guidance on January 17, 2017, to address its electronic PACE application submission timelines and review process. Effective immediately, all new and expansion PACE applications are required to be submitted to CMS through the web-based Health Plan Management System (HPMS). Applicants should review this guidance and be aware of CMS requirements for accessing HPMS. The downloadable PDF of the application and additional information can be found at: https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html

Application Review Process

All new and expansion PACE applications must go through an initial review process by DHCS in order to move forward with submission to CMS via HPMS. The initial submission components are detailed in this letter, which aims to provide DHCS with key organizational background and financial viability documentation. This information is necessary for the State to complete/sign the State Assurance pages and authorize the submission of the full application to DHCS and CMS via HPMS.

Upon submission of the full application to CMS, the State will align its review of the remaining application with the CMS initial 45/90-day clock cycle, dependent on type of application, to create a concurrent review process. The initial CMS 45/90-day clock review begins upon receipt of the completed full application in HPMS, which must include the signed State Assurance pages.

DHCS will review the application according to state and federal laws and regulations. Prior to entering into a contract for the provision of Medi-Cal managed health care services, DHCS may consider any factor it determines to be necessary for consideration (Welfare & Institutions Code §§ 14095 and 14592(b)). This includes considering any information relevant to the issue of whether the application could result in unnecessary duplication of services or impair the financial or service viability of an existing program (42 USCA § 1395eee(e)(2)(B)).

Initial State Review

All new and expansion applications received by DHCS will follow the below initial state review timeframes for application submission:

Action	**Due Date**	**Documents for Submission**	**Reviewer**	**Review Timeframe**
Notification of Intent to DHCS	30 days prior to Initial Application Submission to DHCS	• Letter of Intent • Letter for Support from COHS (if applicable)	DHCS	N/A
Initial Application Submission to DHCS	60 days prior to CMS application submission deadline	• Market Feasibility Study • Letters of Support • Application sections (see Attachment 1)	DHCS	60 Calendar Days
Full Application Submission in HPMS	Align with CMS PACE Application Submission Deadline	• Remaining application sections • State Assurance Page	DHCS/CMS	Align with CMS 45/90 day review clock

Concurrent Federal and State Review

The CMS review process of the PACE Application will include a series of attestations and uploads based on the type of application received, (Initial Application or Service Area Expansion).

Upon completion of the initial CMS 45/90-day clock review of the full application, CMS and/or DHCS may issue a Request for Additional Information (RAI) to the applicant. In the event a RAI is issued, the application is taken off the review clock during this period while the applicant responds to either the CMS and/or DHCS RAI. DHCS will align its remaining review and RAI (if necessary) with CMS timelines and ensure that any necessary changes are communicated to CMS.It is also during this period that DHCS conducts the Readiness Review (RR) onsite survey of the applicant PACE Center, as required. All initial applications and any Service Area Expansion (SAE) application that includes the addition of a new PACE center requires a RR of

the new center. All deficiencies that may be identified during the DHCS Readiness Review onsite survey of the applicant PACE Center must be addressed through a corrective action plan submitted and accepted by DHCS.

Once CMS and/or DHCS have accepted the applicant's RAI response and the Readiness Review onsite survey has been completed by DHCS and the applicant and accepted by CMS, CMS will reinitiate the final 45/90-day clock review cycle. Conclusion of this cycle results in CMS notification to the applicant of final approval or denial.

PACE Growth and Expansion

All PACE growth and expansion falls into one of the below categories:

New PACE Organization – New entity applying to establish a PO

- Entity must identify specific zip codes to be served in one or more counties
- Entity must be able to serve all requested zip codes from PACE Center (subject to 60-minute one way travel time adult day health center (ADHC) requirement)
- Rate development required for each county requested

Existing PO Expansion (Existing County) – PO adding additional zip codes within existing county service area, opening a new PACE Center within existing county service area, or both

- Entity must be able to serve all requested zip codes from PACE Center(s) (subject to 60-minute one way travel time ADHC requirement)
- POs can add zip codes and use Alternative Care Settings (ACS) and Community-based physician waiver as an interim step before building new PACE Center
- Consider rate development/adjustment to account for expansion within the county and account for potential variance and/or changes in utilization
- Zip code only expansions subject to shorter State/CMS review period

Existing PO Expansion (New County) – PO adding zip codes in a new county of operation

- Usually requires a new PACE Center unless the zip codes requested fall within the required radius to be served by existing PACE Center and interdisciplinary team (IDT)
- Requires new rate development

Program Start Date

To align with state budget and rate development processes, all new PO applications and expansion applications requiring new rate development will only be able to begin operations on either January 1 or July 1 of a given year following receipt of final approval from CMS and DHCS. Prospective POs and expansion applicants requiring new rate development should take the available start dates into consideration when preparing to submit an application. Any delays in the application submission or review process may result in the program start getting pushed back to the next available program start date of either January 1 or July 1.

Key Dates for CMS Application Submission

The downloadable PDF of the application and additional information such as application submission deadlines can be found at: https://www.cms.gov/Medicare/Health-Plans/PACE/Downloads/PACE_Application_Training_Feb_2017.pdf.

Initial Application Submission Components

Letter of Intent

All applicants must submit a Letter of Intent (LOI) to DHCS indicating their plans to submit a PACE application. The LOI should identify the applicant; the proposed service area, including a listing of proposed zip codes and a service area map; and the proposed site location for the applicant's PACE center. New applicants proposing to serve an area with an existing or pending PACE plan must identify the overlapping zip codes in their LOI. If an applicant has any questions about whether there is an existing or pending PO operating in its proposed service area it can refer to the DHCS PACE website for a listing of all zip codes by county that POs currently operate in at: http://www.dhcs.ca.gov/individuals/Pages/PACEPlans.aspx. Pending applications for new or expansion POs will also be posted to the DHCS website.

Based on the CMS application submission deadlines, LOI to DHCS would follow the below timeframes:

Letter of Intent to DHCS no later than…	**Initial Application Submission to DHCS no later than…**	**CMS Application Submission Deadlines *last business day of Quarter**
October 1, 2017	November 1, 2017	January 1, 2018
January 1, 2018	February 1, 2018	April 1, 2018
April 1, 2018	May 1, 2018	July 1, 2018
July 1, 2018	August 1, 2018	October 1, 2018

Letters of Support

All PACE applicants must submit letters of support from local entities in the area that the applicant proposes to serve. These may include but are not limited to County Board of Supervisors, County Health and Human Services (HHS) Director, local hospitals, Medi-Cal managed care plans, Independent Physician Associations (IPAs), Commission on Aging, Area Agencies on Aging (AAA), local Multipurpose Senior Services Program (MSSP) Waiver sites, etc. Letters of support should be attached to the LOI. The minimum requirements for letters of support in County Organized Health System counties is provided below.

Market Feasibility Study

All PACE applicants must submit a market analysis of the area that they propose to serve. The feasibility study should include the following:

- Estimate of the number of PACE-eligible individuals
- Description of the methodology/assumptions used to determine potential membership

- Identify all competitive factors impacting the market, such as:
    - Existing POs
    - Managed care plans (MCPs)
    - Demonstration County MCPs (Cal MediConnect and Managed Long-Term Services and Supports (LTSS))
    - Medi-Cal Waiver Programs
    - In-Home Supportive Services (IHSS)
- Identify projected market capture/saturation rates
- Demonstrate that there is an unmet need for PACE in the proposed service area
    - Please note that when multiple applications are received for the same county/zip code service area the order of submission and number of pre-existing plans may have an impact on the decision to approve / deny an application.

Application Narrative

The following PACE application sections must be submitted to DHCS for initial review (see Attachment 1):

New PACE Application	Service Area Expansion (Existing and New County)
• 3.1 – Service Area • 3.2 – Legal Entity and Organization Structure • 3.3 – Governing Body • 3.4 – Fiscal Soundness	• 3.1 – Service Area • 3.4 – Fiscal Soundness • 3.5 – Marketing • 3.13 – Contracted Services • 3.23 – Transportation Services

In addition to the attestations and documents required in the PACE application, DHCS requires detailed narrative in each of these sections to better understand the organizational background and financial standing of the applicant.

Additional Considerations and Limitations

Overlapping service area

New applicants proposing to enter an area already served by an existing PO must identify the overlapping zip codes in their LOI. DHCS will immediately notify any existing and/or pending POs of the new applicant's intent, and the existing and/or pending PO(s) will have an opportunity to submit their own market analysis in response. The counter-analysis must be submitted to DHCS by the initial application submission date. Overlapping service areas are determined at the zip code level. Therefore, if a PO is only servicing a portion of a county and a new or expansion application is requesting a zip code not in the POs service area, by zip code, then the new or expansion application would not trigger notification to the existing/pending PO for an overlapping service area competing market analysis.

DHCS will conduct its own analysis using Medi-Cal data to verify the market feasibility studies that applicants/POs submit. DHCS will evaluate actual numbers of Medi-Cal beneficiaries by age and aid code and will use historical trends of clinical eligibility and market capture to compare against market analyses submitted by applicants/existing POs.

DHCS, in consultation with other State Administering Agencies, has developed a review tool to assist in considering prospective PO applications and the overlapping service area they propose to enter. The review tool is included as Attachment II (Service Area Overlap Review Criteria) to this letter. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Restrictions on Delegation

DHCS is using this PACE Policy Letter to provide explicit clarification to its policy on the use of delegation in the PACE model. DHCS prohibits existing and applicant POs from delegating a separate entity to operate existing and/or additional (expansion) PACE Centers and IDTs. POs are responsible for coordinating and delivering the medical and long term care of frail and vulnerable elderly Californians so that they can remain living safely in their community rather than receiving institutional care. Because of the complexity of this responsibility, the Department has serious concerns with arrangements to delegate the administration of a PACE Center or PACE IDT to third parties. DHCS intends to amend its PACE contracts to include this prohibition. The validity of the DHCS concerns regarding delegation in the PACE model are reflected in the Responses of CMS to Comments presented in the Federal Register, Volume 71, No. 236, pages 71247 to 71263, and 71270 to 71272, regarding Title 42, Code of Federal Regulations, parts 460.60, 460.70, and 460.71.

There is one existing delegated delivery model within PACE in California. The On Lok delegation contract with the Institute of Aging was originally established on August 1, 1996. This model was identified as a contractual arrangement in place on or before July 1, 2000, and was confirmed as “grandfathered” in by CMS in a January 15, 2002, letter. Grandfathering was necessary as the arrangement was not explicitly allowed under the PACE permanent provider regulations at that time.

While DHCS explicitly prohibits full delegation of the fundamental program elements of operation of the PACE Center and IDT, POs have the ability to subcontract for any service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a participant in their home/community are accessible by the PO. POs may enter into subcontracting agreements using the PACE Subcontract Boilerplate template provided by DHCS. Any amendments to the boilerplate template require the Department’s prior written approval.

Please note that DHCS’ prohibition on the use of delegation in PACE does not impact POs option to utilize alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the participant’s home, an inpatient facility, or PACE Center. A PACE participant receives some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center and all PACE participants receiving services at an ACS must be assigned to a PACE Center and IDT.

POs in County Organized Health System Counties

Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county. Specifically, Welfare & Institutions code §14087.5 et seq. provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services in those counties. DHCS will only consider the operation of a

third party PO in a COHS county if the applicant includes a COHS' letter of support that includes the following:

- The COHS's support for the establishment of the independent PO in the county, and;
- The COHS request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county.

The COHS letter of support should be included with the LOI submitted by the applicant organization signifying its intent to expand into a COHS county or to start a new PO in a COHS county. DHCS will ultimately decide whether to move forward with a PACE applicant in a COHS and recommend an 1115 Waiver amendment. Any recommendation from DHCS will be subject to CMS review and approval. In the instance that independent operation of a third party PO is approved, the third party PO must contract directly with the State (DHCS) and CMS as the PACE entity in the three-way program agreement. It is not acceptable for the COHS to contract with DHCS and CMS as the PACE entity in the three-way program agreement and delegate operation of the PO to a separate entity.

This policy reflects the process that was utilized to approve the operation of Redwood Coast PACE in Humboldt County. Redwood Coast PACE was approved to operate independently from the COHS because its PACE application was submitted and accepted prior to the launch of the rural Medi-Cal managed care expansion. The COHS (Partnership Health Plan) endorsed the Redwood Coast PACE application and the exception was made possible by an amendment to California's existing 1115(a)(1) Bridge to Reform Demonstration Waiver.

Licensing

PACE Centers must maintain both a Primary Care Clinic License and an ADHC License. POs must also choose to either maintain a Home Health Agency (HHA) License or contract with a licensed HHA for home health services. Assembly bills 847 (Chapter 315 of 2005) and 577 (Chapter 456 of 2009) established the authority for CDPH/DHCS to authorize exemptions to a PO from licensing and regulatory requirements applicable to clinics, adult day health care services, and home health agencies. If requesting exemption from licensure, a PO must maintain at least one of the PACE Center required licenses (Clinic or ADHC) for each PACE Center. Applicants should consult with the California Department of Public Health (CDPH) to verify licensing requirements. CMS will not accept State Readiness Review until all required licenses are secured. Licensure applications can be found at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/ApplyForLicensure.aspx .

Replacement PACE Centers

Existing POs may move locations or consolidate PACE Center sites by constructing a replacement PACE Center. This scenario is distinct from the construction of a new PACE Center, which requires the submission of a service area expansion application. Replacement Centers require the following transition planning items:

- Administrative Notifications: Notify CMS and DHCS at least 120 days prior to projected transition date.
- Transition Plan: PO's must submit a detailed transition plan that outlines the occupancy timeline, replacement center capacity, contingency planning, transportation plan,

notification to participants, and details of any changes in staffing, policies and procedures, etc.

POs seeking to replace its PACE Center(s) should refer to CMS guidance released on October 21, 2016 that provides further detail on the requirements for transition.

If you have any questions regarding the requirements of this Policy Letter, please contact your Integrated Systems of Care contract manager.

Sincerely,

Jacey Cooper, Acting Division Chief
Integrated System of Care Division

Enclosures

Attachment 1
Attachment 2

Attachment I - PACE Application Required Attestations and Uploads

Attestation Topic	Section #	Initial	SAE	Upload Required (Initial)	Upload Required (SAE)
Service Area	3.1	X	X	X	X
Legal Entity and Organizational	3.2	X		X	
Governing Body	3.3	X		X	
Fiscal Soundness	3.4	X	X	X	X
Marketing	3.5	X	X	X	X
Explanation of Rights	3.6	X		X	
Grievance	3.7	X		X	
Appeals	3.8	X		X	
Enrollment	3.9	X		X	
Disenrollment	3.10	X		X	
Personnel Compliance	3.11	X			
Program Integrity	3.12	X			
Contracted Services	3.13	X	X		
Required Services	3.14	X			
Service Delivery	3.15	X			
Infection Control	3.16	X			
Interdisciplinary Team	3.17	X			
Participant Assessment	3.18	X			
Plan of Care	3.19	X			
Restraints	3.20	X			
Physical Environment	3.21	X			
Emergency and Disaster Preparedness	3.22	X			
Transportation Services	3.23	X	X		
Dietary Services	3.24	X			
Termination	3.25	X		X	
Maintenance of Records & Reporting	3.26	X			
Medical Records	3.27	X			
Quality Assessment Performance Improvement	3.28	X		X	
State Attestations	3.29	X		X	X
Waivers	3.30	X		X (as applicable)	
Application Attestations	3.31	X	X	X	X
State Readiness Review	3.32	X	X (as applicable)	X	X (as applicable)

Attachment II: Service Area Overlap Review Criteria

This tool identifies criteria that DHCS will take into consideration when evaluating applications requesting overlap of existing PACE service areas. DHCS is not limited to the use of only this criteria and will take under consideration additional factors as it determines appropriate to fully assess the application. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Category	Subcategory	Criteria
Service Area Overlap with Existing PACE Operator	Service Area Overlap	Overlap includes less than 25% of potential participants in existing service area
		Overlap includes between 25% and 50% of potential participants in existing service area
		Overlap includes between 50% and 75% of potential participants in existing service area
		Overlap includes over 75% of potential participants in existing service area
	Facility Overlap	Proposed service area includes existing PACE facility or alternative care setting
		Proposed service area does not include existing PACE facility or alternative care setting
Level of Success & Investment of Existing PACE Operators/ Applicants	Market Penetration of Existing Operators in Proposed Service Area	Market penetration under 10%
		Market penetration between 10% and 30%
		Market penetration over 30%
	Recent Investments by Existing PACE Operator(s) and Recent Applicant(s) in Proposed Service Area	Facility investment over $5M in the past year
		Facility investment over $5M between 1 and 2 years
		Facility investment over $5M between 2 and 3 years
		No facility investments over $5M in last 3 years
Local Support	Local Government Support	Formal vote of city council or comparable body in support of new applicant
		Letter of support from city council member or comparable official
		No written support from local government official
	Local Service Provider Involvement	Lead applicant is a services provider in proposed service area
		Supporting applicant is a services provider in proposed service area
		No part of applying entity is services provider in proposed service area

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Date: August 17, 2018

Policy Letter 18-01
Supersedes PACE Policy Letter 17-03

To: Program for All-Inclusive Care for the Elderly (PACE) Organizations

Subject: PACE Application Process

Purpose

The purpose of this Policy Letter is to inform Program of All-Inclusive Care for the Elderly (PACE) Organizations (POs) and potential applicant organizations of the updated Department of Health Care Services (DHCS) application review process and timeline for new PO applications and PACE Expansion applications.

Background

In 2016, the California Legislature passed the PACE Modernization Act Trailer Bill (Sections 31-36 of SB 833, Chapter 30, Statutes of 2016) including updates to the payment and regulatory structure of PACE. The updated California PACE statutes, in part, removed the cap on the number of POs that could operate in the state, and allowed for-profit entities to become POs. As a result, DHCS has seen renewed interest in PACE and an increase in new/expansion applications submitted to DHCS for review. Therefore, DHCS is issuing revised guidance to clarify the Department's expectations with respect to the competitive nature of the review process.

The Centers for Medicare & Medicaid Services (CMS) releases annual updates to its PACE Application Guidance to address its electronic PACE application submission timelines, requirements, and review process. Applicants should review this guidance and be aware of CMS requirements for accessing HPMS. The downloadable PDF of the application and additional information can be found at:
https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html

State Application Review Process

All new and expansion PACE applications must go through an initial review process by DHCS in order to move forward with submission to CMS via HPMS. The initial submission components are detailed in this letter, which aims to provide DHCS with key organizational background and financial viability documentation. This information is

necessary for the State to complete/sign the State Assurance pages and authorize the submission of the full application to DHCS and CMS via HPMS.
Upon submission of the full application to CMS, the State will align its review of the remaining application with the CMS initial 45/90-day clock cycle, dependent on type of application, to create a concurrent review process. The initial CMS 45/90-day clock review begins upon receipt of the completed full application in HPMS, which must include the signed State Assurance pages.

DHCS will review the application according to state and federal laws and regulations. Prior to entering into a contract for the provision of Medi-Cal managed health care services, DHCS may consider any factor it determines to be necessary for consideration (Welfare & Institutions Code §§ 14095 and 14592(b)). This includes considering any information relevant to the issue of whether the application could result in unnecessary duplication of services or impair the financial or service viability of an existing program (42 USCA § 1395eee(e)(2)(B)).

Initial State Review

All new and expansion applications received by DHCS will follow the below initial state review timeframes for application submission:

Action	**Due Date**	**Documents for Submission**	**Reviewer**	**Review Timeframe**
Notification of Intent to DHCS	30 days prior to Initial Application Submission to DHCS	• Letter of Intent • Letter for Support from COHS (if applicable)	DHCS	N/A
Initial Application Submission to DHCS	60 days prior to CMS application submission deadline	• Market Feasibility Study • Letters of Support • Application sections (see Attachment 1)	DHCS	60 Calendar Days
Full Application Submission in HPMS	Align with CMS PACE Application Submission Deadline	• Remaining application sections • State Assurance Page	DHCS/CMS	Align with CMS 45/90 day review clock

Concurrent Federal and State Review

The CMS review process of the PACE Application will include a series of attestations and uploads based on the type of application received, (Initial Application or Service Area Expansion).

Upon completion of the initial CMS 45/90-day clock review of the full application, CMS and/or DHCS may issue a Request for Additional Information (RAI) to the applicant. In the event a RAI is issued, the application is taken off the review clock during this period while the applicant responds to either the CMS and/or DHCS RAI. DHCS will align its remaining review and RAI (if necessary) with CMS timelines and ensure that any necessary changes are communicated to CMS. It is also during this period that DHCS conducts the Readiness Review (RR) onsite survey of the applicant PACE Center, as required. All initial applications and any Service Area Expansion (SAE) application that includes the addition of a new PACE center requires a RR of the new center. All deficiencies that may be identified during the DHCS Readiness Review onsite survey of the applicant PACE Center must be addressed through a corrective action plan submitted and accepted by DHCS.

Once CMS and/or DHCS have accepted the applicant's RAI response and the Readiness Review onsite survey has been completed by DHCS and the applicant and accepted by CMS, CMS will reinitiate the final 45/90-day clock review cycle. Conclusion of this cycle results in CMS notification to the applicant of final approval or denial.

PACE Growth and Expansion

All PACE growth and expansion falls into one of the below categories:

New PACE Organization – New entity applying to establish a PO

- Entity must identify specific zip codes to be served in one or more counties
- Entity must be able to serve all requested zip codes from PACE Center (subject to 60-minute one way travel time adult day health center (ADHC) requirement)
- Rate development required for each county requested

Existing PO Expansion (Existing County) – PO adding additional zip codes within existing county service area, opening a new PACE Center within existing county service area, or both

- Entity must be able to serve all requested zip codes from PACE Center(s) (subject to 60-minute one way travel time ADHC requirement)
- POs can add zip codes and use Alternative Care Settings (ACS) and Community-based physician waiver as an interim step before building new PACE Center
- Consider rate development/adjustment to account for expansion within the county and account for potential variance and/or changes in utilization
- Zip code only expansions subject to shorter CMS review period

Existing PO Expansion (New County) – PO adding zip codes in a new county of operation

- Usually requires a new PACE Center unless the zip codes requested fall within the required radius to be served by existing PACE Center and interdisciplinary team (IDT)
- Requires new rate development

Program Start Date

To align with state budget and rate development processes, all new PO applications and expansion applications requiring new rate development will only be able to begin operations on either January 1 or July 1 of a given year following receipt of final approval from CMS and DHCS. Prospective POs and expansion applicants requiring new rate development should take the available start dates into consideration when preparing to submit an application. Any delays in the application submission or review process may result in the program start getting pushed back to the next available program start date of either January 1 or July 1.

Initial Application Submission Components

Letter of Intent

All applicants must submit a Letter of Intent (LOI) to DHCS indicating their plans to submit a PACE application. The LOI should identify the applicant; the proposed service area, including a listing of proposed zip codes and a service area map; and the proposed site location for the applicant's PACE center. New applicants proposing to serve an area with an existing or pending PACE plan must identify the overlapping zip codes in their LOI. If an applicant has any questions about whether there is an existing or pending PO operating in its proposed service area it can refer to the DHCS PACE website for a listing of all zip codes by county that POs currently operate in at: http://www.dhcs.ca.gov/individuals/Pages/PACEPlans.aspx. Pending applications for new or expansion POs will also be posted to the DHCS website.

CMS application submission deadlines can be found under the application training guide here: https://www.cms.gov/Medicare/Health-Plans/PACE/Overview.html. The LOI to DHCS must be submitted at least 90 days prior to the proposed CMS submission date and the initial application must be submitted at least 60 days prior to the proposed CMS submission date.

Letters of Support

All PACE applicants must submit letters of support from local entities in the area that the applicant proposes to serve. These may include but are not limited to County Board of Supervisors, County Health and Human Services (HHS) Director, local hospitals, Medi-

Cal managed care plans, Independent Physician Associations (IPAs), Commission on Aging, Area Agencies on Aging (AAA), local Multipurpose Senior Services Program (MSSP) Waiver sites, etc. Letters of support should be attached to the LOI. The minimum requirements for letters of support in County Organized Health System counties is provided below.

Market Feasibility Study

All PACE applicants must submit a market analysis of the area that they propose to serve. The feasibility study should include the following:

- Estimate of the number of PACE-eligible individuals
- Description of the methodology/assumptions used to determine potential membership
- Identify all competitive factors impacting the market, such as:
    - Existing POs
    - Managed care plans (MCPs)
    - Demonstration County MCPs (Cal MediConnect and Managed Long-Term Services and Supports (LTSS))
    - Medi-Cal Waiver Programs
    - In-Home Supportive Services (IHSS)
- Identify projected market capture/saturation rates
- Demonstrate that there is an unmet need for PACE in the proposed service area
    - Please note that when multiple applications are received for the same county/zip code service area the order of submission and number of pre-existing plans may have an impact on the decision to approve / deny an application.

State Application Narrative

The following PACE application sections must be submitted to DHCS for initial review (see Attachment 1):

New PACE Application	Service Area Expansion (Existing and New County)
• 3.1 – Service Area • 3.2 – Legal Entity and Organization Structure • 3.3 – Governing Body • 3.4 – Fiscal Soundness	• 3.1 – Service Area • 3.4 – Fiscal Soundness • 3.5 – Marketing • 3.13 – Contracted Services • 3.23 – Transportation Services

In addition to the attestations and documents required in the PACE application, DHCS requires detailed narrative in each of these sections to better understand the organizational background and financial standing of the applicant.

Additional Considerations and Limitations

Overlapping service area

New applicants proposing to enter an area already served by an existing PO must identify the overlapping zip codes in their LOI. DHCS will immediately notify any existing and/or pending POs of the new applicant's intent, and the existing and/or pending PO(s) will have an opportunity to submit their own market analysis in response. The counter-analysis must be submitted to DHCS by the initial application submission date. Overlapping service areas are determined at the zip code level. Therefore, if a PO is only servicing a portion of a county and a new or expansion application is requesting a zip code not in the POs service area, by zip code, then the new or expansion application would not trigger notification to the existing/pending PO for an overlapping service area competing market analysis.

DHCS will conduct its own analysis using Medi-Cal data to verify the market feasibility studies that applicants/POs submit. DHCS will evaluate actual numbers of Medi-Cal beneficiaries by age and aid code and will use historical trends of clinical eligibility and market capture to compare against market analyses submitted by applicants/existing POs.

DHCS, in consultation with other State Administering Agencies, has developed a review tool to assist in considering prospective PO applications and the overlapping service area they propose to enter. The review tool is included as Attachment II (Service Area Overlap Review Criteria) to this letter. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Restrictions on Delegation

DHCS is using this PACE Policy Letter to provide explicit clarification to its policy on the use of delegation in the PACE model. DHCS prohibits existing and applicant POs from delegating a separate entity to operate existing and/or additional (expansion) PACE Centers and IDTs. POs are responsible for coordinating and delivering the medical and long term care of frail and vulnerable elderly Californians so that they can remain living safely in their community rather than receiving institutional care. Because of the complexity of this responsibility, the Department has serious concerns with arrangements to delegate the administration of a PACE Center or PACE IDT to third parties. DHCS intends to amend its PACE contracts to include this prohibition. The validity of the DHCS concerns regarding delegation in the PACE model are reflected in the Responses of CMS to Comments presented in the Federal Register, Volume 71, No. 236, pages 71247 to 71263, and 71270 to 71272, regarding Title 42, Code of Federal Regulations, parts 460.60, 460.70, and 460.71.

There is one existing delegated delivery model within PACE in California. The On Lok delegation contract with the Institute of Aging was originally established on August 1, 1996. This model was identified as a contractual arrangement in place on or before July 1, 2000, and was confirmed as "grandfathered" in by CMS in a January 15, 2002, letter. Grandfathering was necessary as the arrangement was not explicitly allowed under the PACE permanent provider regulations at that time.

While DHCS explicitly prohibits full delegation of the fundamental program elements of operation of the PACE Center and IDT, POs have the ability to subcontract for any service(s), as determined necessary by the IDT, to ensure that all services necessary to maintain a participant in their home/community are accessible by the PO. POs may enter into subcontracting agreements using the PACE Subcontract Boilerplate template provided by DHCS. Any amendments to the boilerplate template require the Department's prior written approval.

Please note that DHCS' prohibition on the use of delegation in PACE does not impact POs option to utilize alternative care settings (ACS). An ACS is any physical location in the POs approved service area other than the participant's home, an inpatient facility, or PACE Center. A PACE participant receives some (but not all) PACE Center services at an ACS on a fixed basis during usual and customary PACE center hours of operation. An ACS cannot replace a PACE Center and all PACE participants receiving services at an ACS must be assigned to a PACE Center and IDT.

POs in County Organized Health System Counties

Counties that provide Medi-Cal services through a County Organized Health System (COHS) are the sole source for Medi-Cal services in that county. Specifically, Welfare & Institutions code §14087.5 et seq. provides that counties that elect to organize as COHS hold the exclusive right to contract for Medi-Cal services in those counties. DHCS will only consider the operation of a third party PO in a COHS county if the applicant includes a COHS' letter of support that includes the following:

- The COHS's support for the establishment of the independent PO in the county, and;
- The COHS request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county.

The COHS letter of support should be included with the LOI submitted by the applicant organization signifying its intent to expand into a COHS county or to start a new PO in a COHS county. DHCS will ultimately decide whether to move forward with a PACE applicant in a COHS and recommend an 1115 Waiver amendment. Any recommendation from DHCS will be subject to CMS review and approval. In the instance that independent operation of a third party PO is approved, the third party PO must contract directly with the State (DHCS) and CMS as the PACE entity in the three-way program agreement. It is not acceptable for the COHS to contract with DHCS and CMS as the PACE entity in the three-way program agreement and delegate operation of the PO to a separate entity.

This policy reflects the process that was utilized to approve the operation of Redwood Coast PACE in Humboldt County. Redwood Coast PACE was approved to operate independently from the COHS because its PACE application was submitted and accepted prior to the launch of the rural Medi-Cal managed care expansion. The COHS (Partnership Health Plan) endorsed the Redwood Coast PACE application and the exception was made possible by an amendment to California's existing 1115(a)(1) Bridge to Reform Demonstration Waiver.

Licensing

PACE Centers must maintain both a Primary Care Clinic License and an ADHC License. POs must also choose to either maintain a Home Health Agency (HHA) License or contract with a licensed HHA for home health services. Assembly bills 847 (Chapter 315 of 2005) and 577 (Chapter 456 of 2009) established the authority for CDPH/DHCS to authorize exemptions to a PO from licensing and regulatory requirements applicable to clinics, adult day health care services, and home health agencies. If requesting exemption from licensure, a PO must maintain at least one of the PACE Center required licenses (Clinic or ADHC) for each PACE Center. Applicants should consult with the California Department of Public Health (CDPH) to verify licensing requirements. CMS will not accept State Readiness Review until all required licenses are secured. Licensure applications can be found at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/ApplyForLicensure.aspx .

Replacement PACE Centers

Existing POs may move locations or consolidate PACE Center sites by constructing a replacement PACE Center. This scenario is distinct from the construction of a new PACE Center, which requires the submission of a service area expansion application. Replacement Centers require the following transition planning items:

- Administrative Notifications: Notify CMS and DHCS at least 120 days prior to projected transition date.
- Transition Plan: PO's must submit a detailed transition plan that outlines the occupancy timeline, replacement center capacity, contingency planning, transportation plan, notification to participants, and details of any changes in staffing, policies and procedures, etc.

POs seeking to replace its PACE Center(s) should refer to CMS guidance released on October 21, 2016 that provides further detail on the requirements for transition. Replacement Centers are not subject to the January 1 or July 1 start dates.

If you have any questions regarding the requirements of this Policy Letter, please contact your Integrated Systems of Care contract manager.

Sincerely,

ORIGINAL SIGNED BY

Sarah Eberhardt-Rios, Division Chief
Integrated System of Care Division

Enclosures

Attachment 1
Attachment 2

Attachment I - PACE Application Required Attestations and Uploads

Attestation Topic	Section #	Initial	SAE	Upload Required (Initial)	Upload Required (SAE)
Service Area	3.1	X	X	X	X
Legal Entity and Organizational	3.2	X	X	X	X
Governing Body	3.3	X	X	X	X
Fiscal Soundness	3.4	X	X	X	X
Marketing	3.5	X	X	X	X
Explanation of Rights	3.6	X	X	X	X
Grievance	3.7	X	X	X	X
Appeals	3.8	X	X	X	X
Enrollment	3.9	X	X	X	X
Disenrollment	3.10	X	X	X	X
Personnel Compliance	3.11	X	X		
Program Integrity	3.12	X	X		
Contracted Services	3.13	X	X		
Required Services	3.14	X	X		
Service Delivery	3.15	X	X		
Infection Control	3.16	X	X		
Interdisciplinary Team	3.17	X	X		
Participant Assessment	3.18	X	X		
Plan of Care	3.19	X	X		
Restraints	3.20	X	X		
Physical Environment	3.21	X	X		
Emergency and Disaster	3.22	X	X		
Transportation Services	3.23	X	X		
Dietary Services	3.24	X	X		
Termination	3.25	X	X	X	X
Maintenance of Records &	3.26	X	X		
Medical Records	3.27	X	X		
Quality Assessment Performance Improvement	3.28	X	X	X	X
State Attestations	3.29	X	X	X	X
Waivers	3.30	X	X	X (as applicable)	
Application Attestations	3.31	X	X	X	X
State Readiness Review	3.32	X	X (as applicable)	X	X (as applicable)

Attachment II: Service Area Overlap Review Criteria

This tool identifies criteria that DHCS will take into consideration when evaluating applications requesting overlap of existing PACE service areas. DHCS is not limited to the use of only this criteria and will take under consideration additional factors as it determines appropriate to fully assess the application. DHCS will take all factors into consideration and ultimately decide whether to move forward with signing the State Assurance page.

Category	Subcategory	Criteria
Service Area Overlap with Existing PACE Operator	Service Area Overlap	Overlap includes less than 25% of potential participants in existing service area
		Overlap includes between 25% and 50% of potential participants in existing service area
		Overlap includes between 50% and 75% of potential participants in existing service area
		Overlap includes over 75% of potential participants in existing service area
	Facility Overlap	Proposed service area includes existing PACE facility or alternative care setting
		Proposed service area does not include existing PACE facility or alternative care setting
Level of Success & Investment of Existing PACE Operators/ Applicants	Market Penetration of Existing Operators in Proposed Service Area	Market penetration under 10%
		Market penetration between 10% and 30%
		Market penetration over 30%
	Recent Investments by Existing PACE Operator(s) and Recent Applicant(s) in Proposed Service Area	Facility investment over $5M in the past year
		Facility investment over $5M between 1 and 2 years
		Facility investment over $5M between 2 and 3 years
		No facility investments over $5M in last 3 years
Local Support	Local Government Support	Formal vote of city council or comparable body in support of new applicant
		Letter of support from city council member or comparable official
		No written support from local government official
	Local Service Provider Involvement	Lead applicant is a services provider in proposed service area
		Supporting applicant is a services provider in proposed service area
		No part of applying entity is services provider in proposed service area

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PACE

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PACE Response to Regulatory Guidance

Board of Directors Meeting

September 6, 2018

Phil Tsunoda, Executive Director, Public Policy and Public Affairs

Current PACE Landscape

- Alternative and new methods of expansion are in line with the national PACE growth initiative, known as PACE 2.0

- CalOptima PACE has a variety of expansion strategies in place
  - Alternative Care Settings
  - Community-based physicians
  - Service area expansion to south Orange County

- DHCS Policy Letters create an opportunity for independent PACE centers to operate in County Organized Health System (COHS) counties

DHCS Policy Letters

- October 2017 and August 2018 letters outline the policies affecting the application review process and timelines, as well as restrictions on delegation

- Of note to CalOptima, the policy letters require a letter of support from the COHS health plan as part of an independent PACE Organization (PO) application

DHCS Policy Letters (Cont.)

"DHCS will only consider the operation of an independent PO in a COHS county if the applicant includes a letter of support from the COHS stating:

- The COHS' support for the establishment of the independent PO in the county
- The COHS' request that DHCS submit an amendment to the 1115 Waiver to allow the independent operation of a specified PO in the county"

Regulatory Approval

- CalOptima's *only role* with regard to an independent PO applying to operate in a COHS county is *at the beginning*, in considering whether to issue a letter of support and associated 1115 Waiver amendment request
- Lengthy application process follows this sequence:
  1) Independent PO requests from COHS a letter of support, which includes the 1115 Waiver amendment request
  2) If letter of support is provided, independent PO submits to DHCS a letter stating its intent to apply to operate a PACE center
  3) DHCS considers whether to submit to CMS the waiver amendment request
  4) If DHCS submits, CMS considers whether to approve the waiver amendment request
  5) If CMS approves the waiver amendment, DHCS evaluates the independent PO application
  6) If DHCS approves the application, CMS evaluates the independent PO application

Process for Consideration of Letter of Support

- CalOptima proposes a fair and objective evaluation process that includes, but is not limited to, certain elements:

- Application timeline window
  - Independent POs may submit letter of support requests during the period of November 1, 2018, to January 31, 2019

- Geographic ZIP code designation
  - Independent POs must include the specific ZIP codes the PO is interested in serving within Orange County

Process for Consideration of Letter of Support (Cont.)

- Threshold Criteria (20%)
  1. Operating experience
  2. Financial soundness
  3. Quality performance
  4. Demographic competence

- Primary Criteria (80%)
  5. Potential impact to CalOptima PACE program

Criterion 1: Operating Experience

- Show a minimum of five years of experience operating a PACE center
- Provide evidence of regulatory audits with no sanctions
- Submit operational policies and procedures
- Obtain reference letters from member advocates, providers and community stakeholders

Criterion 2: Financial Soundness

- Submit financial statements for the three most recent consecutive years
  - Income statements
  - Balance sheets
- Report important financial metrics
  - Liquidity
  - Debt ratio
  - Short-term viability
  - Delinquency
- Obtain third-party risk report via Dunn and Bradstreet where available

Criterion 3: Quality Performance

- Report performance against current CalPACE averages
  - Participants residing in nursing homes
  - Hospital admissions per 1,000
  - Hospital days per 1,000
  - Hospital readmission rate
  - Emergency room visits per 1,000
  - Participant satisfaction rating

Criterion 4: Demographic Competence

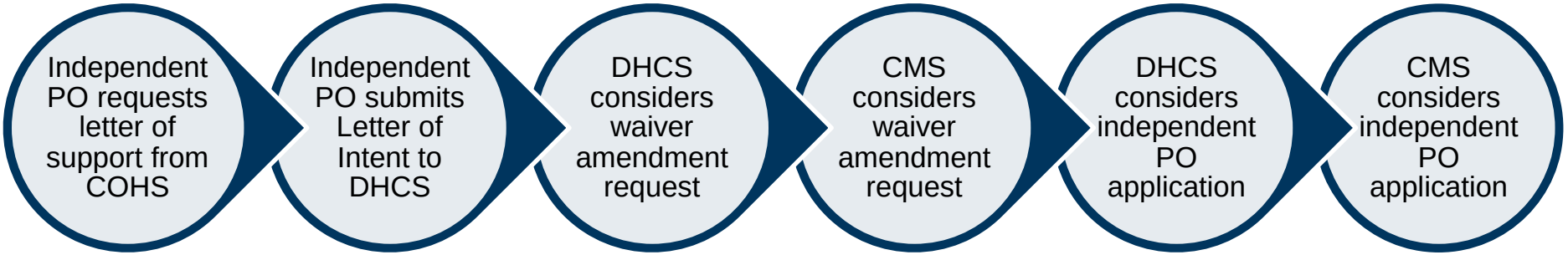
- Provide a general PACE demographic profile of the ZIP code area of interest

- Demonstrate staff experience/understanding in serving PACE participants similar to the potential participants in the geographic area of interest
  - Training in cultural competency
  - Language diversity and capability
  - Accommodations for low literacy
  - Response to socioeconomic factors

Criterion 5: Impact to CalOptima PACE

- State potential impacts of an independent PO on CalOptima's existing PACE program

PACE Application Process



If the application is approved, the independent PO would contract directly with DHCS and CMS

Recommended Actions

- Approve CalOptima PACE expansion strategy in response to state regulatory guidance.

- Authorize the CEO to implement a process to consider letters of support for qualified organizations seeing to establish an independent PACE facility in Orange County.
  - Staff to bring back for Board approval any recommendation regarding a letter of support for an independent PO letter.

INNOVATIVE INTEGRATED HEALTH, INC.

Phillip B. Tsunoda
Vice President, Government Relations

August 7, 2025

CalOptima Health Board of Directors
505 City Parkway West
Orange, CA 92868

SUBJECT: SUPPORT FOR COBAR ITEM -
PACE LETTER OF SUPPORT POLICY PA 9003

Dear Board Members,

Innovative Integrated Health (IIH), the owner and operator of Orange County PACE, respectively expresses its support for the proposed action item regarding CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE) Letter of Support policy PA 9003.

This policy will greatly assist in providing much needed health care and social service access to the significant PACE-eligible population in Orange County.

As you know, PACE provides a comprehensive program of health and wellness services for the county's frail, low-income senior population. Services include primary, preventative and acute medical care as well as social, recreational, nutritional and personal care services in a day center and clinic setting.

Through the PACE program, these services promote independence and enable participants to continue to live at home and in the community instead of residing in an institutional setting.

Because these services are vital for the continuation and enhancement of the quality of life for the vulnerable PACE population, Innovative Integrated Health (IIH) and Orange County PACE wholly supports this COBAR item.

Thank you for your attention.

Most sincerely,

Phillip Tsunoda
Vice-President, Government Relations

CalOptima health Board Action Agenda Referral

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

Report Item

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

Contacts

Veronica Carpenter, Chief Administrative Officer, (714) 657-900-1161
Deanne Thompson, Executive Director, Marketing and Communications, (657) 550-4736

Recommended Actions

1. Authorize implementation of a Medi-Cal Eligibility Outreach Strategy in response to upcoming federal and state legislative changes;
2. Authorize closing the Board-approved initiative for the Adult Expansion Outreach Strategy to promote enrollment of eligible adults ages 26-49 into full-scope Medi-Cal, regardless of immigration status and appropriate the unspent remaining balance of $800,000 to implement the Medi-Cal Eligibility Outreach Strategy; and
3. Authorize the Chief Executive Officer to execute agreements for expenditures as necessary to implement proposed activities.

Background

In December 2023, the Board authorized an appropriation of up to $5.0 million from existing reserves to inform the public about a new law in California that would provide adults 26-49 years of age with access to full-scope Medi-Cal services, regardless of immigration status. This outreach strategy began on July 1, 2024, and ended on June 30, 2025. This initiative has been fully implemented, with a remaining balance of $800,000. Given recent changes to Medi-Cal enrollment eligibility in California's Fiscal Year 2025-26 budget, the promotion of enrollment into Medi-Cal of the undocumented population has concluded.

Separately, recent federal and state legislative changes to Medi-Cal eligibility requirements, such as the end of continuous eligibility for children age 5 and under, the implementation of work requirements, and more frequent redetermination for certain adult members, will require a broad, multifaceted outreach and education campaign throughout Orange County to help members retain their Medi-Cal coverage in the future.

Discussion

Similar to CalOptima Health's communications efforts in prior years to bring awareness to members and the community about Medi-Cal renewal and CalFresh enrollment, CalOptima Health will partner with the County of Orange Social Services Agency (SSA) on a Medi-Cal Eligibility Outreach Strategy. Based on guidance from the state, staff plans to customize these messages for Orange County and distribute them in English, Spanish, and Vietnamese. The Medi-Cal Eligibility Outreach Strategy will employ a multi-channel approach to identify and reach members in need of the information to support continuity of Medi-Cal coverage,

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including:

- An integrated media campaign that includes print, radio, digital, and broadcast media outlets throughout Orange County;
- Toolkit materials (*e.g.*, flyers, posters, newsletter articles, and social media posts) in multiple languages for use by providers, community health centers, community-based organizations, and other community stakeholders; and
- Press release(s), social media promotion, and information on the CalOptima Health website.

The total estimated cost for implementing these strategies is approximately $800,000, starting September 5, 2025, through such time as the eligibility changes are implemented. Regulators have not finalized specific timeframes for these changes, but the changes are expected to begin in 2026. Therefore, staff is requesting flexibility to spend these funds across multiple CalOptima Health fiscal years, as appropriate.

Fiscal Impact

Staff is not requesting any additional appropriations for the Medi-Cal Eligibility Outreach Strategy. An unspent remaining balance of $800,000 from the Adult Expansion Outreach Strategy approved by the Board on December 7, 2023, will fund this initiative.

Rationale for Recommendation

CalOptima Health will work collaboratively with SSA to ensure broad awareness of changes to Medi-Cal eligibility to help ensure members understand how to retain their Medi-Cal coverage. Staff recommends the use of funds to support the implementation of a Medi-Cal Eligibility Outreach Strategy.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

/s/ Michael Hunn *08/29/2025*
Authorized Signature **Date**

Continued to a Future Meeting

CalOptima Health Board Action Agenda Referral

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

Report Item
18. Approve Modifications to CalOptima Health Purchasing Policy

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

Recommended Action
Approve modifications to CalOptima Health Policy GA.5002: Purchasing, effective September 4, 2025.

Background
California Government Code section 54202 requires that every local agency adopt and implement policies and procedures, including procurement regulations governing purchases of supplies, equipment, and services by the local agency. All procurement of the local agency must be in accordance with the adopted policies and all provisions of governing law.

The CalOptima Health Board of Directors (Board) may delegate certain authority to staff to execute procurement decisions provided there are adequate safeguards to guide the use of the delegated authority and prevent abuse.

On September 10, 1996, the Board adopted CalOptima Health Policy GA.5002: Purchasing, to provide guidance on procurement related to CalOptima Health's operations. This policy was last revised on May 2, 2024.

Discussion
The main components of the policy remain unchanged, including existing dollar thresholds and signature requirements. Staff is not requesting additional authority. The updated policy version provides clarifications to some sections and adds a section regarding the duration of contracts. The revised policy:

- Specifies the party responsible for issuing Purchase Orders;
- Adds utilities, state and local government expenses, and specialized services to procurements that are categorically non-competitive to the section listing procurements that are always considered sole source;
- Adds a section on contract duration, criteria for use of long-term contracts of up to ten years, and requirement for Board approval for long-term contracts exceeding the duration specified in the policy; and
- Includes other non-substantive changes (*i.e.*, formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

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Fiscal Impact

The recommended action to modify CalOptima Health Policy GA.5002 is operational in nature and has no additional fiscal impact beyond what was included in the CalOptima Health Fiscal Year 2025-26 Operating and Capital Budgets.

Rationale for Recommendation

Updates to the CalOptima Health purchasing policy are recommended to ensure compliance with the California Public Contract and Government Codes and the federal procurement regulations, and to enhance the efficiency and clarity of CalOptima's operations and governance. The section on contract duration is not intended to limit options, but to ensure awareness and agreement among all parties involved in CalOptima governance and oversight.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Proposed CalOptima Health Policy GA.5002: Purchasing

/s/ Michael Hunn *08/28/2025*
Authorized Signature **Date**

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Policy:	GA.5002
Title:	**Purchasing**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	09/10/1996
Revised Date:	08/01/2025
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

I. PURPOSE

These policies establish a process for the procurement of goods and services essential to the operations of CalOptima Health. The intent of these policies is to ensure transparency and integrity in procurement and to maximize the purchasing value of funds entrusted to CalOptima Health. Accordingly, competitive procurement is the preferred method of procurement unless competition is not feasible due to an emergency, restricted availability of goods or services, or other circumstances that would justify waivers of competitive requirements.

II. POLICIES

A. Ethics

1. General Conduct

   Each CalOptima Health employee, officer, Board of Directors ("Board") member, and agent of CalOptima Health ("Covered Person") is subject to the Conflict of Interest Laws of the State of California ("State") and the CalOptima Health Code of Conduct. Any Covered Person who violates these standards will be subject to the relevant penalties, sanctions, and other disciplinary actions.

2. Gratuities, Kickbacks, and Contingency Fees

   a. Except as allowed under CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments, no Covered Person may solicit or accept any personal gift or anything of value from any person or entity to which a purchase order or contract is under consideration for award, has been awarded, or may be awarded, or because of any action taken or to be taken in the performance of the Covered Person's duties. Any Covered Person failing to adhere to the above will be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, including possible dismissal.

   b. CalOptima Health employees must adhere to all provisions of CalOptima Health Policies AA.1204: Gift, Honoraria, and Travel Payments, and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health.

3. Confidential Information

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a. No Covered Person may use Confidential Information, or information regarding a procurement that has not been made public or become subject to the California Public Records Act, for their actual or anticipated personal gain, or the actual or anticipated personal gain of any other person related to such CalOptima Health employee by blood, marriage, or by common commercial or financial interest. A Covered Person failing to adhere to this requirement will be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, up to and including dismissal.

b. No Covered Person may divulge Confidential Information to any vendor, consultant, or contractor outside the scope of any agreement that may exist with the vendor, consultant, or contractor.

4. Vendor Relations

a. A Covered Person may not meet with vendors, consultants, and/or contractors regarding financial agreements unless a representative of the Vendor Management Department ("Vendor Management") is present at the meeting.

b. Outside of a procurement process, vendor demonstrations may be obtained to gather information from potential suppliers of goods or services and to learn about available options in the marketplace, provided that the vendor understands that no contract will result from the demonstration and no advantage will be gained should a procurement follow. Efforts should be made to obtain more than one demonstration. If demonstrations are desired, the business owner must notify Vendor Management.

c. While a procurement is active and until a contract has been awarded or the procurement has been terminated, no Covered Person may:

i. Communicate, discuss, or disclose any information regarding bids, proposals, the identity of bidders or proposers, deliberations, or negotiations, to any other person, including other CalOptima Health employees and supervisors not directly involved in the solicitation, other than the communication defined in the solicitation; or

ii. Communicate with Offerors regarding their offers or other offers outside of evaluation committee meetings, unless the information has been made public or relates only to general administrative requirements, such as due dates, website access, or similar subjects.

d. Personal Conflict of Interest

No employee, officer, Board member, or agent of CalOptima Health may participate in the selection, award, or administration of an agreement with a contractor, or in any decision that may have a foreseeable impact on a contractor if a conflict of interest, real or apparent, exists. Such a conflict arises when any one of the following has a financial or other interest in the firm selected for award:

i. A CalOptima Health employee, officer, Board member, or agent;

ii. CalOptima Health employee's, officer's, Board member's, or agent's spouse or children;

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iii. The CalOptima Health employee's, officer's, Board member's, or agent's domestic or business partner;

iv. An organization that employs or has made an offer of employment to any of the above.

e. Organizational Conflict of Interest

i. Organizational conflicts of interest are circumstances that arise out of a party's business or financial interests, familial relationships, contractual relationships, organizational structure, or existing or past activities, including any prior interactions or work with CalOptima Health, that result or can result in:

a) A competitive advantage with respect to a CalOptima Health procurement;

b) Impairment or potential impairment of the party's ability to perform impartially or to render objective and impartial assistance or advice to CalOptima Health under existing or other potential contracts;

c) Unequal access to information or influence on requirements, such as unreleased budgets, scopes of work, selection criteria; or

d) The appearance or reality of impropriety or unfair competitive advantage with respect to any of CalOptima Health's procurements or contracts.

ii. A party with an organizational conflict of interest, or with employees or team members who have a conflict of interest, may not be awarded a contract resulting from the procurement in which the organizational conflict of interest existed.

iii. No person or entity may submit an offer in response to a CalOptima Health solicitation if the person or entity has:

a) Directly assisted in drafting or in preparing the specifications, requirements, or cost estimates for that procurement; or

b) Had access and exposure to information pertinent to that procurement that was unavailable to other Offerors and would provide a competitive advantage to its possessor.

iv. General advice or information offered as part of CalOptima Health's general information-gathering and market research involving multiple entities at the beginning stages of developing a solicitation and prior to its release, and comments made subsequent to the release of the solicitation, will not create a conflict of interest, nor would contracts that are part of a single competitive procurement conducted in more than one stage.

B. Requisition Limits, Signatories and Authority

1. Vendor Management

Unless otherwise exempted or required by these policies or applicable law, the Chief Financial Officer (CFO), with the assistance of Vendor Management, is charged with responsibility for the following:

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a. Acquiring equipment, supplies and services for all CalOptima Health departments;

b. Identifying qualified vendors and developing and promoting good vendor relationships;

c. Educating and training employees and vendors on these policies and the purchasing process;

d. Providing assistance to CalOptima Health departments in preparing specifications and analyzing offers; and

e. Awarding contracts and ensuring vendor performance through contract administration.

2. Requisitions

a. A requisition ~~for the purchase~~is required to commence a new procurement of supplies, equipment, or services, or to initiate a Change Order, or to issue a Purchase Order. Requisitions may only be approved by a properly authorized person. The Board has delegated requisition authority to the Chief Executive Officer (CEO). The CEO has further delegated that authority in the amounts provided below.

b. Any person in a position of delegated authority may designate a person of the same level or higher, in writing, to act in their stead when that person is unavailable.

c. Vendor Management has authority to question the quality, quantity, kind, and source of materials and services being requisitioned.

3. Requisition Approval Limits – Goods, Non-Medical Professional Services, Public Works

Employee Position	**Approval Limit**
Manager	$ 1,000
Director	10,000
Executive Director or Officer	100,000
CEO or Chief Operating Officer (COO)	Over 100,000

4. Requisition Approval Limits – Capital Projects

Employee Position	**Approval Limit**
Manager	$ 0
Director	0
Executive Director or Officer	100,000
CEO or COO	Over 100,000

5. Requisition Approval Limits – Information Technology

Employee Position	**Approval Limit**
Manager	$ 10,000
Director	50,000
Executive Director or Officer	100,000
CEO or COO	Over 100,000

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6. Approvals

Funding for all requisitions will be approved by the Board through:

a. The annual operating or capital budget;

b. Specific Board action; or

c. A budget allocation change, in accordance with CalOptima Health Policy GA.5003: Budget Approval and Budget Reallocation.

7. Signatures

a. Budget submissions must meet the requirements outlined in CalOptima Health Policy GA.3202: CalOptima Health Signature Authority.

b. Signature authorization for contracts, agreements, leases, and purchase orders is addressed in CalOptima Health Policy GA.3202: CalOptima Health Signature Authority. No CalOptima Health employees, officers, and agents may bind, or appear to bind, CalOptima Health in any way, financially, or otherwise, except as provided for in accordance with that policy.

8. Purchase Orders

a. On approval of a requisition, Vendor Management will create a Purchase Order (PO), listing the date of the order, a description of the goods or services ordered, the price and quantity of the goods or services ordered, shipping or delivery information, discount terms if any, the PO number, and the terms and conditions of the PO.

b. Purchase Orders may only be issued by Vendor Management.

C. Methods of Procurement

1. General Requirements

a. All solicitations must contain:

i. A description of the scope and the general objectives of the procurement, including clear descriptions and information regarding the goods or services to be provided or problems to be solved;

ii. Instructions and requirements for the submission of questions, comments, and offers;

iii. Due dates and times for pre-submission materials, conferences, and submission of offers;

iv. Communication protocols between Offerors or potential Offerors and CalOptima Health staff during the solicitation and until CalOptima Health makes the contract award or terminates the solicitation;

v. The basis for the contract award;

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vi. The basis on which CalOptima Health will make payment, setting out expected service levels, milestones, performance measures, deliverables, and any other factors that will be used.

b. If factors such as discounts, transportation costs, and life cycle costs will be included when determining low price, those factors must be clearly stated in the solicitation.

c. Vendor Management will make all Formal and Informal Procurements, and during a procurement, will be the exclusive point of contact with Offerors regarding the procurement.

d. Vendor Management will be responsible for documenting the procurement and certifying that proper procedures and protocols were followed. Vendor Management may disqualify any firm or individual that violates these policies from participating in a procurement.

2. Informal Procurement

a. Micro Purchases

i. Micro Purchases are those where the estimated cost is under $50,000 and may be made without solicitation of bids.

ii. CalOptima Health must annually self-certify its $50,000 Micro Purchase limit by way of a CEO memorandum, which includes a justification for the $50,000 limit.

b. Small Purchases

i. Small Purchases are those where the estimated cost is between $50,000 and $250,000. They do not require formal advertising but require at least three competitive quotes. If it is not possible to obtain at least three quotes, documentation of the attempt to obtain the quotes must be kept in the procurement file.

ii. If a contract will not be awarded solely on price, Vendor Management must approve the selection criteria before the solicitation is released and price must be a consideration in making the selection.

iii. A purchase may not be split to avoid Formal Procurement. If the same goods or services are repeatedly needed by the same department, Vendor Management may require Formal Procurement.

3. Formal Procurement

a. General Requirements

i. Unless otherwise provided by these policies or by applicable law, a Formal Procurement method must be used for purchases of goods, non-medical professional services, Public Works, Capital Projects, computer equipment, and telecommunications goods and services where the expected cost is estimated to be more than $250,000.00.

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ii. Formal Procurement requires full and open competition in which all qualified entities are allowed to compete.

iii. All Formal Procurements must include major required terms and conditions, including federal or State requirements, or a copy of a draft contract.

b. Competitive Bidding

i. Under this procurement method, Vendor Management issues a solicitation; all interested parties are allowed to submit bids; and the contract is awarded to the responsive, responsible bidder offering the lowest price for the requested goods or services.

ii. For competitive bidding to be feasible, the following conditions must be present:

a) Adequate specifications and clear requirements of items or tasks are available;

b) Award can be made principally on the basis of price;

c) There are entities willing to participate; and

d) Negotiations are not needed before selecting the low-price bidder for award.

iii. Tie Bids - In the case of tie bids, Vendor Management may choose to re-advertise for bids or to select the winning bidder by drawing lots in the presence of at least three witnesses.

iv. Competitive Bidding is required for Multipurpose Senior Services Program contracts and for Public Works contracts that will use a traditional project delivery method.

c. Requests for Proposals ("RFP")

i. The RFP procedure is a competitive, best-value procurement. Unless prohibited by federal or State law, an RFP may be used to acquire goods or services, other than architectural and engineering services that must be acquired by Qualification-Based Solicitations. RFPs are used when:

a) Independent judgment and specialized knowledge, expertise, or training on the part of the provider is required; and

b) CalOptima Health can define its needs but is interested in varying approaches to providing the requested goods or services and is seeking creative or innovative approaches in which professional expertise and methods may differ greatly; and

c) The goal is the best overall value rather than the lowest price.

ii. In addition to the requirements for all solicitations, an RFP must include all of the following:

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a) The specific factors and the relative importance of each factor that will be used to evaluate proposals, including the relative significance of price, which must be a factor in all RFPs; and

b) Whether one or several awards may be made, and if more than one award, the basis for the awards.

iii. Proposal Evaluations

a) Vendor Management and the relevant department will select an evaluation team for each RFP, consisting of CalOptima Health employees and, if needed, outside subject matter experts ("SMEs") engaged as voting or non-voting members to explain complex proposal terms.

b) Proposals will first be reviewed by Vendor Management for responsiveness. Proposals Vendor Management finds non-responsive that cannot be made responsive without providing an advantage to the proposer will be rejected.

c) Prior to receiving proposals from Vendor Management, each member of the evaluation committee and each SME who believes that they, or family members, or individuals with whom they have a close relationship, may have a financial interest in the outcome of the procurement process, must inform Vendor Management and recuse themselves from further participation in the procurement process. All persons given access to proposals must sign a confidentiality and conflict of interest statement.

d) No proposals may be discussed outside of the evaluation committee until a selection has been made.

e) Proposals may not be evaluated on any factor not specified in the solicitation as an evaluation factor. After initial evaluations, the committee may select one or more proposers for contract award or for further discussions and interviews. Following interviews, proposers remaining in the competitive range may be asked to submit Best and Final Offers or one or more may be selected for contract award.

d. Qualifications-Based Selection

i. Qualifications-Based Section ("QBS") is a type of Formal Procurement in which all qualified consultants are invited to submit their qualifications for a particular project or tasks. Pursuant to Government Code §4525 *et. seq.*, selection is based on demonstrated competence and qualifications for the types of services to be performed.

ii. CalOptima Health will use a QBS for acquisition of architectural, engineering, environmental, and land surveying services when a traditional project delivery method is to be used.

iii. Under a QBS process, an evaluation committee will review the qualifications submitted by qualified consultants. The evaluation process will conform to the requirements established for RFPs, except that price will not be an evaluation factor in the initial selection of the most qualified consultant. Once the most qualified consultant has been selected, price negotiations may commence with

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that consultant. If CalOptima Health cannot establish a fair and reasonable price with the most qualified consultant, negotiations may commence with the next most qualified consultant.

iv. CalOptima Health may use QBS for service providers when pre-set reimbursement rates have been established for all providers or when Vendor Management determines that an alternative Formal Procurement methodology is not feasible.

e. Two-Step Sealed Bidding

i. Step one follows the procedures for an RFP except that prices will not be considered in the initial evaluation of proposals.

ii. In step two, those who submitted proposals that were found acceptable by the evaluation committee in step one are invited to submit sealed bids. The bids will be reviewed, and award made in accordance with the requirements for competitive sealed bids.

iii. In addition to the general requirements for all solicitations, a solicitation for two-step sealed bidding must include at a minimum:

a) A statement that the two-step method will be used;

b) Instructions that technical proposals in step one need not include price information;

c) The specific factors and the relative importance of each factor that will be used to evaluate proposals in the initial phase;

d) The number of contract awards that may be made, and if more than one, the basis for allocation of awards;

e) The basis on which CalOptima Health will pay bidders, setting out expected service levels, milestones, performance measures, deliverables and other factors that will be used; and

f) Anticipated contract terms and conditions.

4. Negotiated Acquisition

Negotiated Acquisition, in which CalOptima Health negotiates directly with one or more vendors may only be used if it is determined that it is not practicable or advantageous to award a contract by Formal Procurement because:

a. There is a need to respond to a court order, stipulation, or consent decree;

b. An existing vendor has been terminated or has otherwise become unavailable, a successor is urgently needed, and a Formal Procurement would cause a break in needed services or make provision of needed services difficult or impossible;

c. Funding, when first provided, did not allow sufficient time to conduct a Formal Procurement;

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d. Formal Procurement has failed to secure an appropriate supplier of the required goods or services;

e. There is a limited number of vendors available and able to provide the required goods or services; or

f. There is an unforeseen need to procure additional or changed work during an ongoing construction project.

5. Cooperative and Piggyback Purchases

a. Vendor Management may purchase goods or services pursuant to a cooperative purchasing agreement provided that the procuring entity's procurement process is consistent with these purchasing policies.

b. Vendor Management may issue a joint solicitation with any governmental or public body or agency for the procurement of any goods or services, consistent with these purchasing policies.

c. Vendor Management may also Piggyback on contracts let by the U.S. government or any state, including agencies and subdivisions of a state, under the following circumstances:

i. The vendor consents to the Piggyback and is not barred or otherwise not qualified to contract with CalOptima Health;

ii. The contract's products or services are what CalOptima Health is seeking;

iii. Vendor Management determines that the price CalOptima Health will pay is fair and reasonable;

iv. The original contract was solicited under procedures substantially similar to CalOptima Health's solicitation methods;

v. CalOptima Health will have its own contract with the vendor and will have no relationship with or obligations to the original contracting entity.

6. State and Federal Contracts

At the discretion of Vendor Management, CalOptima Health may use California's Leveraged Procurement Agreements and Multiple Award Schedules, as well as schedules of the federal government, to purchase directly from suppliers through existing government contracts.

7. Non-Competitive Procurement, Non-Emergency

a. Grants received by CalOptima Health

Competitive procurement need not be used when CalOptima Health accepts a grant in which a provider or other cooperating entity has been specified.

b. Sole Source

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i. A contract may be awarded for goods or services without competitive bidding when Vendor Management, with assistance from the business unit when necessary, determines in writing that the goods or services:

a) Are proprietary or only available from a single source;

b) Involve maintenance or service of equipment from the original manufacturer or seller;

c) Are additions to a critical system already procured from the vendor or that must conform to or become part of existing products or equipment, such as replacement parts; or

d) Have unique performance factors.

ii. The following are always considered sole-source:

a) Subscriptions to professional and scholarly journals;

b) Memberships or licensure in professional organizations;

c) Conference or meeting facilities;

d) State and local government agency charges such as permits, inspections, fees, etc.;

e) Utilities;

~~d)~~f) Legal counsel; or

~~Other experts.~~

g) Expert witnesses or consultants with specialized licenses, training, knowledge, or skills that are not readily and widely available.

8. Non-Competitive Procurement - Emergency

a. Emergency purchases are allowed to mitigate or remedy the effects of an unexpected situation that may impose significant provable loss to CalOptima Health or pose immediate danger to a person's health, safety, welfare, or property. When an emergency condition arises and the need cannot be met through normal procurement methods, an emergency purchase may be made with such competition as is feasible under the circumstances. Contracts and other documents related to such emergency procurements must be executed in accordance with the requirements of CalOptima Health Policy GA.3202: CalOptima Health Signature Authority.

b. The person responsible for the emergency purchase must provide written documentation stating the basis of the emergency purchase and the reasoning for the selection of the particular contractor or goods to the CEO. The CEO will provide a report to the Board on the emergency purchase. Normal purchasing procedures must be followed as soon as the immediate danger is over.

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D. Procedures for Formal Procurement

1. Publicity

   Except in cases of emergency or where circumstances require an immediate contract, CalOptima Health will post information regarding a formal solicitation on its website and will comply with relevant California requirements regarding publicity.

2. Public Works Projects

   Procurement and award of Public Works Projects will comply with relevant provisions of California statutes, regulations, and other rules regarding Public Works, including rules regarding bonds, prevailing rates, and Department of Industrial Relations registration.

3. Receipt and Review of Offers

   a. Vendor Management will review submissions for responsiveness. Vendor Management will reject submissions that are non-responsive and that cannot be made responsive within timelines set by Vendor Management without disadvantaging another Offeror.

   b. Prior to recommending a contract award, Vendor Management will make a determination of an Offeror's responsibility based on initial information provided in the submission, information submitted upon request, information resulting from inquiry into the Offeror's references and background, and CalOptima Health's own knowledge of the Offeror, taking into consideration matters such as the Offeror's integrity, compliance with public policy, record of past performance, and financial and technical resources. Offerors determined to be non-responsible and who cannot be made to be responsible within timelines set by CalOptima Health will be notified and will not be considered further.

   c. On making a finding of non-responsiveness, Vendor Management will notify the firm or individual. If the firm or individual can demonstrate, within three days, that the materials submitted were in fact responsive, Vendor Management may reconsider the determination.

   d. On making a finding of non-responsibility, Vendor Management will notify the firm or individual and provide three business days to respond. CalOptima Health may accept the response and modify its original determination or may reject the response and notify the respondent. CalOptima Health's decision will be final.

4. Contract Award

   Following a check for responsiveness and responsibility, contracts for price-based solicitations will be awarded to the responsive, responsible individual or firm offering the lowest price, and contracts for best value solicitations such as RFPs will be awarded to the responsive, responsible Offeror that, in the opinion of CalOptima Health, provides the best value.

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5. Protests

   a. Protests or objections regarding formal procurements may be filed with Vendor Management regarding the procurement process, solicitation or addendum content, or contract award. CalOptima Health will review only protests submitted by prospective or actual Offerors. Protests by prospective or actual subcontractors or uninvolved parties will be rejected.

   b. Protests must include detailed grounds for the protest, supported with technical data, documentary evidence, names of witnesses, and other pertinent information related to the subject being protested, and the law, rule, regulation, or policy upon which the protest is based, alleging a clear violation of a specific law, rule, regulation, or policy.

   c. Vendor Management will establish procedures for accepting and receiving protests, which will be included in each formal solicitation.

E. Miscellaneous Provisions

1. Real Property Transactions

   CalOptima Health may not enter into any transaction for the purchase, sale, license, lease (including any sublease or lease assignment, whether CalOptima Health is the lessor, lessee, sublessor, sublessee, assignor or assignee), or termination of lease of any real property, or enter into negotiations related to such transactions, without the prior approval of the Board, pursuant to a Board action addressed solely to the transaction or set of related transactions that sets forth the parameters under which the negotiations may proceed. Such negotiations and transactions on behalf of CalOptima Health are to be carried out exclusively by the person or persons designated by the Board.

2. Multipurpose Senior Services Program (MSSP) Purchases

   Equipment and supplies procured by CalOptima Health with funding from the MSSP waiver are the property of the State of California and must comply with procedures and standards outlined by the State of California. Such purchases under the MSSP do not include equipment and supplies purchased for an individual member, which become the property of the individual member.

3. Information Technology

   Contracts for software licenses, software maintenance, or computer equipment must be approved in writing by the Information Technology Services Department.

4. Healthcare Services

   For healthcare services contracts that require procurement, the Provider Operations Department will coordinate award with Vendor Management with approval of an appropriate signing party under CalOptima Health Policy GA.3202: CalOptima Health Signature Authority, within limits delegated by the Board and with approval of contract templates (and any deviations) by the Legal Counsel.

F. Contract Modifications and Change Orders

1. General requirements

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If a contract modification will result in an increase in the aggregate contract value, a Change Order must be approved by an individual authorized to approve contracts of that amount.

2. Standard Contracts

   a. Cumulative increases to a contract procured through Informal Procurement may not increase the value of the contract to an amount greater than the Informal Procurement limit.

   b. A contract amendment may not increase the value of a contract by over 30% of the original contract amount, unless:

      i. The value increase is due to price increases in supplies, materials, or labor;

      ii. The need for additional goods or services could not be accurately projected and the percentage of increase does not justify re-soliciting;

      iii. An emergency exists which does not permit re-bidding; or

      iv. The additional amount is due to alternates or options that were contemplated by the original contract.

   c. Contract modifications that materially alter the scope of work or services originally contemplated, and that could not have reasonably been foreseen when the solicitation was released, require a new procurement. If modifications are due to emergency conditions that could not have been foreseen, the modifications must be justified in writing and approved by the Board.

3. Construction Contracts

   a. Modifications and Change Orders that alter the responsibilities of the parties under the contract require amendments.

   b. Modifications to a contract's value due to design errors or omissions, or for additional work, require appropriate price analysis to determine price reasonableness and may not be made if the additional value is not determined fair and reasonable by Vendor Management and the business owner. The determination and methodology must be recorded, provided with any request for a change order, and approved by Vendor Management.

   c. Modifications to renovation or construction contracts that do not increase the contract's value are permitted if the vendor can furnish:

      i. A substantially equal product with a cost savings to the Project; or

      ii. A superior product at the original contract price.

   d. Modifications to renovation or construction contracts that increase the contract value may be permitted if:

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i. The modification fits within the scope of the contract and is required to complete the work contemplated as part of the original scope of the contract; or

ii. The reason for the change is something that was unanticipated, could not have been foreseen at the time the original contract was awarded, and is necessary to complete the project.

e. Modifications to renovation or construction contracts may not, individually or in the aggregate, represent significant material deviations from the quality, amount, type, or cost of work originally contemplated by the contract, or require the contractor to perform duties substantially different from those originally bargained for. Modifications that alter the original Scope of Work such that they amount to material changes that result in a fundamental redesign of a project require a new procurement and may require termination of the original contract.

4. Architecture, Engineering, Environmental and Land Surveying Contracts

Architectural, landscape architectural, engineering, environmental, and land surveying services that must be procured by QBS pursuant to Government Code §4525 *et. seq.*, may not be modified to include work that could not have been reasonably contemplated as being within the original scope of services requested, or to include additional projects that were not contemplated within the original scope.

G. Contract Duration

1. The duration of a contract should be commensurate with the type of contract contemplated, the scope and complexity of the subject matter, industry standards, changes or potential changes in technology or market conditions, and the expected time for delivery of the goods and services requested.

2. CalOptima Health may enter into long-term contracts of up to ten years to take advantage of one or more of the following:

a. Lower total costs and better overall ROI, including employee training, amortization of startup and deployment costs, and cancellation charges;

b. Continuity and stability of services and performance;

c. Standardization of CalOptima Health systems; or

d. Compliance with legal requirements.

3. Factors to consider when establishing a long-term contract may include:

a. Time and resources required for replacement and deployment of new systems, procedures, or processes;

b. The scale of risk associated with engaging a replacement contractor;

c. The number of departments affected;

d. Required compatibility with State or federal systems;

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e. Whether better pricing would be offered over a longer term;

f. Vendor recoupment of high start-up costs or capital investment over a longer contract period;

g. Infrastructure stability and CalOptima Health's internal technology roadmap;

h. Requirements that the vendor establish linkages with other vendors;

i. Programs where the population to be served is fragile or difficult to serve and the well-being of the population would be jeopardized by frequent vendor changes;

j. The service provided involves the development and continuity of a personal, supportive, or therapeutic relationship between a caregiver and client is an integral part of treatment and the treatment would be jeopardized by severance of that relationship as a result of vendor change;

k. The services involve funding a center-based facility that requires obtaining permits, approvals, leases, or capital improvements by the service provider.

4. The CalOptima Health Board must approve contracts of over ten years.

III. PROCEDURE

Not Applicable

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. 10 U.S. Code §2306
~~A.~~B. California Fair Political Practices Commission Form 700 - Statement of Economic Interests
~~B.~~C. California Government Code
~~C.~~D. California Public Contract Code
~~D.~~E. CalOptima Health Code of Conduct
~~E.~~F. CalOptima Health Compliance Plan
~~F.~~G. CalOptima Health Conflict of Interest Code
~~G.~~H. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
~~H.~~I. CalOptima Health Policy AA.1216: Solicitation and Receipt of Gifts to CalOptima Health
~~I.~~J. CalOptima Health Policy GA.3202: CalOptima Health Signature Authority
~~J.~~K. CalOptima Health Policy GA.5003: Budget Approval and Budget Reallocation
~~K.~~L. CalOptima Health Resolution No. 12-03101-01
M. Title 2, Code of Federal Regulations (CFR) Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards
N. Title 48, Code of Federal Regulations (CFR) §17.204(e)

VI. REGULATORY AGENCY APPROVALS

None to Date

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VII. BOARD ACTIONS

Date	Meeting
11/01/1994	Regular Meeting of the CalOptima Board of Directors
09/10/1996	Special Meeting of the CalOptima Board of Directors
11/04/1997	Regular Meeting of the CalOptima Board of Directors
12/02/1997	Regular Meeting of the CalOptima Board of Directors
01/11/2000	Regular Meeting of the CalOptima Board of Directors
09/09/2003	Regular Meeting of the CalOptima Board of Directors
03/01/2012	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
09/01/2022	Regular Meeting of the CalOptima Health Board of Directors
05/02/2024	Regular Meeting of the CalOptima Health Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/10/1996	GA.5002	Procurement Policy	Administrative
Revised	11/04/1997	GA.5002	Procurement Policy	Administrative
Revised	12/02/1997	GA.5002	Procurement Policy	Administrative
Revised	01/11/2000	GA.5002	Procurement Policy	Administrative
Revised	01/01/2004	GA.5002	Procurement Policy	Administrative
Revised	03/01/2012	GA.5002	Purchasing Policy	Administrative
Revised	06/07/2018	GA.5002	Purchasing	Administrative
Revised	09/01/2022	GA.5002	Purchasing	Administrative
Revised	05/02/2024	GA.5002	Purchasing	Administrative
Revised	08/01/2025	GA.5002	Purchasing	Administrative

For 20250

IX. GLOSSARY

Term	Definition
Bid	An offer to supply goods or services for a specific price.
Capital Project	Acquisition, improvement, modification, or construction of infrastructure assets or equipment that will be used beyond the accounting period in which they are purchased and will be shown as capital assets on financial statements.
Change Order	A post-award modification to a contract that may alter the Scope of Work and may also affect the cost or time for completion of the work.
Confidential Information	All non-public or proprietary information relating to CalOptima Health or a CalOptima Health member designated as confidential or that reasonably should be understood to be confidential given the nature of the information and the circumstances of its disclosure or acquisition.
Formal Procurement	A solicitation method that provides full and open competition in which all responsible parties are allowed to submit competing offers, and that generally includes public advertising of the solicitation.
Informal Procurement	A solicitation method in which, due to the anticipated value of the goods or services solicited, full and open competition and formal advertising is not required and offers may be solicited directly from potential providers of the requested goods or services.
Information Technology	Equipment, hardware, software, systems, and procedures used for acquiring, creating, storing, processing, displaying, or exchanging electronic data.
Micro Purchase	Purchase of goods, non-medical professional services, Public Works projects, capital projects, and computer equipment and telecommunications goods and services estimated to cost less than $50,000.
Offeror	A person or entity submitting a response to a solicitation.
Piggyback	A form of intergovernmental purchasing in which a governmental entity uses (or "piggybacks") on another organization's contract that provides the new user the same pricing and terms as those offered to the original entity.
Public Works	The erection, construction, alteration, repair, or improvement of any public structure, building, or road.
Purchase Order	A document instructing a supplier to deliver goods or services, whether issued independently or under the authority of a contract.
Qualifications-Based Selection ("QBS")	A competitive procurement where design professionals (engineers, land surveyors, architects, etc.) are initially selected based on their qualifications and demonstrated competence, and price is not a factor in the initial evaluation and selection.
Request for Proposals ("RFP")	A solicitation announcing CalOptima Health's interest in obtaining goods or services and inviting interested parties to propose methods of providing those goods or services, where the final selection and contract award will be based on the best overall value to CalOptima Health.
Responsible Bidder/Proposer	A bidder or proposer able to meet all requirements of a solicitation and subsequent contract, possessing or able to obtain the financial and technical capability to perform and to comply with all legal and regulatory requirements, having a history of satisfactory performance, not on a federal or state debarment or suspension list, and generally demonstrating the quality, fitness, capacity, and experience to satisfactorily perform under the anticipated contract.
Responsive Bid/Proposal	A bid or proposal that conforms in all material respects to the requirements of the solicitation.
Scope of Work (SOW)	A description of the detailed requirements of a project, including the objectives, milestones, deliverables, outcomes, management, and the rights and obligations of the parties related to the specific project.

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Term	Definition
Small Purchase	One-time purchases of goods or services estimated to cost from $50,000 to $250,000.

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Policy:	GA.5002
Title:	**Purchasing**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	09/10/1996
Revised Date:	08/01/2025
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

These policies establish a process for the procurement of goods and services essential to the operations of CalOptima Health. The intent of these policies is to ensure transparency and integrity in procurement and to maximize the purchasing value of funds entrusted to CalOptima Health. Accordingly, competitive procurement is the preferred method of procurement unless competition is not feasible due to an emergency, restricted availability of goods or services, or other circumstances that would justify waivers of competitive requirements.

II. POLICIES

A. Ethics

1. General Conduct

   Each CalOptima Health employee, officer, Board of Directors ("Board") member, and agent of CalOptima Health ("Covered Person") is subject to the Conflict of Interest Laws of the State of California ("State") and the CalOptima Health Code of Conduct. Any Covered Person who violates these standards will be subject to the relevant penalties, sanctions, and other disciplinary actions.

2. Gratuities, Kickbacks, and Contingency Fees

   a. Except as allowed under CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments, no Covered Person may solicit or accept any personal gift or anything of value from any person or entity to which a purchase order or contract is under consideration for award, has been awarded, or may be awarded, or because of any action taken or to be taken in the performance of the Covered Person's duties. Any Covered Person failing to adhere to the above will be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, including possible dismissal.

   b. CalOptima Health employees must adhere to all provisions of CalOptima Health Policies AA.1204: Gift, Honoraria, and Travel Payments, and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health.

3. Confidential Information

a. No Covered Person may use Confidential Information, or information regarding a procurement that has not been made public or become subject to the California Public Records Act, for their actual or anticipated personal gain, or the actual or anticipated personal gain of any other person related to such CalOptima Health employee by blood, marriage, or by common commercial or financial interest. A Covered Person failing to adhere to this requirement will be subject to any disciplinary proceeding deemed appropriate by CalOptima Health, up to and including dismissal.

b. No Covered Person may divulge Confidential Information to any vendor, consultant, or contractor outside the scope of any agreement that may exist with the vendor, consultant, or contractor.

4. Vendor Relations

a. A Covered Person may not meet with vendors, consultants, and/or contractors regarding financial agreements unless a representative of the Vendor Management Department ("Vendor Management") is present at the meeting.

b. Outside of a procurement process, vendor demonstrations may be obtained to gather information from potential suppliers of goods or services and to learn about available options in the marketplace, provided that the vendor understands that no contract will result from the demonstration and no advantage will be gained should a procurement follow. Efforts should be made to obtain more than one demonstration. If demonstrations are desired, the business owner must notify Vendor Management.

c. While a procurement is active and until a contract has been awarded or the procurement has been terminated, no Covered Person may:

i. Communicate, discuss, or disclose any information regarding bids, proposals, the identity of bidders or proposers, deliberations, or negotiations, to any other person, including other CalOptima Health employees and supervisors not directly involved in the solicitation, other than the communication defined in the solicitation; or

ii. Communicate with Offerors regarding their offers or other offers outside of evaluation committee meetings, unless the information has been made public or relates only to general administrative requirements, such as due dates, website access, or similar subjects.

d. Personal Conflict of Interest

No employee, officer, Board member, or agent of CalOptima Health may participate in the selection, award, or administration of an agreement with a contractor, or in any decision that may have a foreseeable impact on a contractor if a conflict of interest, real or apparent, exists. Such a conflict arises when any one of the following has a financial or other interest in the firm selected for award:

i. A CalOptima Health employee, officer, Board member, or agent;

ii. CalOptima Health employee's, officer's, Board member's, or agent's spouse or children;

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iii. The CalOptima Health employee's, officer's, Board member's, or agent's domestic or business partner;

iv. An organization that employs or has made an offer of employment to any of the above.

e. Organizational Conflict of Interest

i. Organizational conflicts of interest are circumstances that arise out of a party's business or financial interests, familial relationships, contractual relationships, organizational structure, or existing or past activities, including any prior interactions or work with CalOptima Health, that result or can result in:

a) A competitive advantage with respect to a CalOptima Health procurement;

b) Impairment or potential impairment of the party's ability to perform impartially or to render objective and impartial assistance or advice to CalOptima Health under existing or other potential contracts;

c) Unequal access to information or influence on requirements, such as unreleased budgets, scopes of work, selection criteria; or

d) The appearance or reality of impropriety or unfair competitive advantage with respect to any of CalOptima Health's procurements or contracts.

ii. A party with an organizational conflict of interest, or with employees or team members who have a conflict of interest, may not be awarded a contract resulting from the procurement in which the organizational conflict of interest existed.

iii. No person or entity may submit an offer in response to a CalOptima Health solicitation if the person or entity has:

a) Directly assisted in drafting or in preparing the specifications, requirements, or cost estimates for that procurement; or

b) Had access and exposure to information pertinent to that procurement that was unavailable to other Offerors and would provide a competitive advantage to its possessor.

iv. General advice or information offered as part of CalOptima Health's general information-gathering and market research involving multiple entities at the beginning stages of developing a solicitation and prior to its release, and comments made subsequent to the release of the solicitation, will not create a conflict of interest, nor would contracts that are part of a single competitive procurement conducted in more than one stage.

B. Requisition Limits, Signatories and Authority

1. Vendor Management

Unless otherwise exempted or required by these policies or applicable law, the Chief Financial Officer (CFO), with the assistance of Vendor Management, is charged with responsibility for the following:

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a. Acquiring equipment, supplies and services for all CalOptima Health departments;

b. Identifying qualified vendors and developing and promoting good vendor relationships;

c. Educating and training employees and vendors on these policies and the purchasing process;

d. Providing assistance to CalOptima Health departments in preparing specifications and analyzing offers; and

e. Awarding contracts and ensuring vendor performance through contract administration.

2. Requisitions

a. A requisition is required to commence a new procurement of supplies, equipment, or services, or to initiate a Change Order, or to issue a Purchase Order. Requisitions may only be approved by a properly authorized person. The Board has delegated requisition authority to the Chief Executive Officer (CEO). The CEO has further delegated that authority in the amounts provided below.

b. Any person in a position of delegated authority may designate a person of the same level or higher, in writing, to act in their stead when that person is unavailable.

c. Vendor Management has authority to question the quality, quantity, kind, and source of materials and services being requisitioned.

3. Requisition Approval Limits – Goods, Non-Medical Professional Services, Public Works

Employee Position	**Approval Limit**
Manager	$ 1,000
Director	10,000
Executive Director or Officer	100,000
CEO or Chief Operating Officer (COO)	Over 100,000

4. Requisition Approval Limits – Capital Projects

Employee Position	**Approval Limit**
Manager	$ 0
Director	0
Executive Director or Officer	100,000
CEO or COO	Over 100,000

5. Requisition Approval Limits – Information Technology

Employee Position	**Approval Limit**
Manager	$ 10,000
Director	50,000
Executive Director or Officer	100,000
CEO or COO	Over 100,000

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6. Approvals

   Funding for all requisitions will be approved by the Board through:

   a. The annual operating or capital budget;

   b. Specific Board action; or

   c. A budget allocation change, in accordance with CalOptima Health Policy GA.5003: Budget Approval and Budget Reallocation.

7. Signatures

   a. Budget submissions must meet the requirements outlined in CalOptima Health Policy GA.3202: CalOptima Health Signature Authority.

   b. Signature authorization for contracts, agreements, leases, and purchase orders is addressed in CalOptima Health Policy GA.3202: CalOptima Health Signature Authority. No CalOptima Health employees, officers, and agents may bind, or appear to bind, CalOptima Health in any way, financially, or otherwise, except as provided for in accordance with that policy.

8. Purchase Orders

   a. On approval of a requisition, Vendor Management will create a Purchase Order (PO), listing the date of the order, a description of the goods or services ordered, the price and quantity of the goods or services ordered, shipping or delivery information, discount terms if any, the PO number, and the terms and conditions of the PO.

   b. Purchase Orders may only be issued by Vendor Management.

C. Methods of Procurement

1. General Requirements

   a. All solicitations must contain:

      i. A description of the scope and the general objectives of the procurement, including clear descriptions and information regarding the goods or services to be provided or problems to be solved;

      ii. Instructions and requirements for the submission of questions, comments, and offers;

      iii. Due dates and times for pre-submission materials, conferences, and submission of offers;

      iv. Communication protocols between Offerors or potential Offerors and CalOptima Health staff during the solicitation and until CalOptima Health makes the contract award or terminates the solicitation;

      v. The basis for the contract award;

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vi. The basis on which CalOptima Health will make payment, setting out expected service levels, milestones, performance measures, deliverables, and any other factors that will be used.

b. If factors such as discounts, transportation costs, and life cycle costs will be included when determining low price, those factors must be clearly stated in the solicitation.

c. Vendor Management will make all Formal and Informal Procurements, and during a procurement, will be the exclusive point of contact with Offerors regarding the procurement.

d. Vendor Management will be responsible for documenting the procurement and certifying that proper procedures and protocols were followed. Vendor Management may disqualify any firm or individual that violates these policies from participating in a procurement.

2. Informal Procurement

a. Micro Purchases

i. Micro Purchases are those where the estimated cost is under $50,000 and may be made without solicitation of bids.

ii. CalOptima Health must annually self-certify its $50,000 Micro Purchase limit by way of a CEO memorandum, which includes a justification for the $50,000 limit.

b. Small Purchases

i. Small Purchases are those where the estimated cost is between $50,000 and $250,000. They do not require formal advertising but require at least three competitive quotes. If it is not possible to obtain at least three quotes, documentation of the attempt to obtain the quotes must be kept in the procurement file.

ii. If a contract will not be awarded solely on price, Vendor Management must approve the selection criteria before the solicitation is released and price must be a consideration in making the selection.

iii. A purchase may not be split to avoid Formal Procurement. If the same goods or services are repeatedly needed by the same department, Vendor Management may require Formal Procurement.

3. Formal Procurement

a. General Requirements

i. Unless otherwise provided by these policies or by applicable law, a Formal Procurement method must be used for purchases of goods, non-medical professional services, Public Works, Capital Projects, computer equipment, and telecommunications goods and services where the expected cost is estimated to be more than $250,000.00.

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ii. Formal Procurement requires full and open competition in which all qualified entities are allowed to compete.

iii. All Formal Procurements must include major required terms and conditions, including federal or State requirements, or a copy of a draft contract.

b. Competitive Bidding

i. Under this procurement method, Vendor Management issues a solicitation; all interested parties are allowed to submit bids; and the contract is awarded to the responsive, responsible bidder offering the lowest price for the requested goods or services.

ii. For competitive bidding to be feasible, the following conditions must be present:

a) Adequate specifications and clear requirements of items or tasks are available;

b) Award can be made principally on the basis of price;

c) There are entities willing to participate; and

d) Negotiations are not needed before selecting the low-price bidder for award.

iii. Tie Bids - In the case of tie bids, Vendor Management may choose to re-advertise for bids or to select the winning bidder by drawing lots in the presence of at least three witnesses.

iv. Competitive Bidding is required for Multipurpose Senior Services Program contracts and for Public Works contracts that will use a traditional project delivery method.

c. Requests for Proposals ("RFP")

i. The RFP procedure is a competitive, best-value procurement. Unless prohibited by federal or State law, an RFP may be used to acquire goods or services, other than architectural and engineering services that must be acquired by Qualification-Based Solicitations. RFPs are used when:

a) Independent judgment and specialized knowledge, expertise, or training on the part of the provider is required; and

b) CalOptima Health can define its needs but is interested in varying approaches to providing the requested goods or services and is seeking creative or innovative approaches in which professional expertise and methods may differ greatly; and

c) The goal is the best overall value rather than the lowest price.

ii. In addition to the requirements for all solicitations, an RFP must include all of the following:

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a) The specific factors and the relative importance of each factor that will be used to evaluate proposals, including the relative significance of price, which must be a factor in all RFPs; and

b) Whether one or several awards may be made, and if more than one award, the basis for the awards.

iii. Proposal Evaluations

a) Vendor Management and the relevant department will select an evaluation team for each RFP, consisting of CalOptima Health employees and, if needed, outside subject matter experts ("SMEs") engaged as voting or non-voting members to explain complex proposal terms.

b) Proposals will first be reviewed by Vendor Management for responsiveness. Proposals Vendor Management finds non-responsive that cannot be made responsive without providing an advantage to the proposer will be rejected.

c) Prior to receiving proposals from Vendor Management, each member of the evaluation committee and each SME who believes that they, or family members, or individuals with whom they have a close relationship, may have a financial interest in the outcome of the procurement process, must inform Vendor Management and recuse themselves from further participation in the procurement process. All persons given access to proposals must sign a confidentiality and conflict of interest statement.

d) No proposals may be discussed outside of the evaluation committee until a selection has been made.

e) Proposals may not be evaluated on any factor not specified in the solicitation as an evaluation factor. After initial evaluations, the committee may select one or more proposers for contract award or for further discussions and interviews. Following interviews, proposers remaining in the competitive range may be asked to submit Best and Final Offers or one or more may be selected for contract award.

d. Qualifications-Based Selection

i. Qualifications-Based Section ("QBS") is a type of Formal Procurement in which all qualified consultants are invited to submit their qualifications for a particular project or tasks. Pursuant to Government Code §4525 *et. seq.*, selection is based on demonstrated competence and qualifications for the types of services to be performed.

ii. CalOptima Health will use a QBS for acquisition of architectural, engineering, environmental, and land surveying services when a traditional project delivery method is to be used.

iii. Under a QBS process, an evaluation committee will review the qualifications submitted by qualified consultants. The evaluation process will conform to the requirements established for RFPs, except that price will not be an evaluation factor in the initial selection of the most qualified consultant. Once the most qualified consultant has been selected, price negotiations may commence with

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that consultant. If CalOptima Health cannot establish a fair and reasonable price with the most qualified consultant, negotiations may commence with the next most qualified consultant.

iv. CalOptima Health may use QBS for service providers when pre-set reimbursement rates have been established for all providers or when Vendor Management determines that an alternative Formal Procurement methodology is not feasible.

e. Two-Step Sealed Bidding

i. Step one follows the procedures for an RFP except that prices will not be considered in the initial evaluation of proposals.

ii. In step two, those who submitted proposals that were found acceptable by the evaluation committee in step one are invited to submit sealed bids. The bids will be reviewed, and award made in accordance with the requirements for competitive sealed bids.

iii. In addition to the general requirements for all solicitations, a solicitation for two-step sealed bidding must include at a minimum:

a) A statement that the two-step method will be used;

b) Instructions that technical proposals in step one need not include price information;

c) The specific factors and the relative importance of each factor that will be used to evaluate proposals in the initial phase;

d) The number of contract awards that may be made, and if more than one, the basis for allocation of awards;

e) The basis on which CalOptima Health will pay bidders, setting out expected service levels, milestones, performance measures, deliverables and other factors that will be used; and

f) Anticipated contract terms and conditions.

4. Negotiated Acquisition

Negotiated Acquisition, in which CalOptima Health negotiates directly with one or more vendors may only be used if it is determined that it is not practicable or advantageous to award a contract by Formal Procurement because:

a. There is a need to respond to a court order, stipulation, or consent decree;

b. An existing vendor has been terminated or has otherwise become unavailable, a successor is urgently needed, and a Formal Procurement would cause a break in needed services or make provision of needed services difficult or impossible;

c. Funding, when first provided, did not allow sufficient time to conduct a Formal Procurement;

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d. Formal Procurement has failed to secure an appropriate supplier of the required goods or services;

e. There is a limited number of vendors available and able to provide the required goods or services; or

f. There is an unforeseen need to procure additional or changed work during an ongoing construction project.

5. Cooperative and Piggyback Purchases

a. Vendor Management may purchase goods or services pursuant to a cooperative purchasing agreement provided that the procuring entity's procurement process is consistent with these purchasing policies.

b. Vendor Management may issue a joint solicitation with any governmental or public body or agency for the procurement of any goods or services, consistent with these purchasing policies.

c. Vendor Management may also Piggyback on contracts let by the U.S. government or any state, including agencies and subdivisions of a state, under the following circumstances:

i. The vendor consents to the Piggyback and is not barred or otherwise not qualified to contract with CalOptima Health;

ii. The contract's products or services are what CalOptima Health is seeking;

iii. Vendor Management determines that the price CalOptima Health will pay is fair and reasonable;

iv. The original contract was solicited under procedures substantially similar to CalOptima Health's solicitation methods;

v. CalOptima Health will have its own contract with the vendor and will have no relationship with or obligations to the original contracting entity.

6. State and Federal Contracts

At the discretion of Vendor Management, CalOptima Health may use California's Leveraged Procurement Agreements and Multiple Award Schedules, as well as schedules of the federal government, to purchase directly from suppliers through existing government contracts.

7. Non-Competitive Procurement, Non-Emergency

a. Grants received by CalOptima Health

Competitive procurement need not be used when CalOptima Health accepts a grant in which a provider or other cooperating entity has been specified.

b. Sole Source

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i. A contract may be awarded for goods or services without competitive bidding when Vendor Management, with assistance from the business unit when necessary, determines in writing that the goods or services:

a) Are proprietary or only available from a single source;

b) Involve maintenance or service of equipment from the original manufacturer or seller;

c) Are additions to a critical system already procured from the vendor or that must conform to or become part of existing products or equipment, such as replacement parts; or

d) Have unique performance factors.

ii. The following are always considered sole-source:

a) Subscriptions to professional and scholarly journals;

b) Memberships or licensure in professional organizations;

c) Conference or meeting facilities;

d) State and local government agency charges such as permits, inspections, fees, etc.;

e) Utilities;

f) Legal counsel; or

g) Expert witnesses or consultants with specialized licenses, training, knowledge, or skills that are not readily and widely available.

8. Non-Competitive Procurement - Emergency

a. Emergency purchases are allowed to mitigate or remedy the effects of an unexpected situation that may impose significant provable loss to CalOptima Health or pose immediate danger to a person's health, safety, welfare, or property. When an emergency condition arises and the need cannot be met through normal procurement methods, an emergency purchase may be made with such competition as is feasible under the circumstances. Contracts and other documents related to such emergency procurements must be executed in accordance with the requirements of CalOptima Health Policy GA.3202: CalOptima Health Signature Authority.

b. The person responsible for the emergency purchase must provide written documentation stating the basis of the emergency purchase and the reasoning for the selection of the particular contractor or goods to the CEO. The CEO will provide a report to the Board on the emergency purchase. Normal purchasing procedures must be followed as soon as the immediate danger is over.

D. Procedures for Formal Procurement

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1. Publicity

   Except in cases of emergency or where circumstances require an immediate contract, CalOptima Health will post information regarding a formal solicitation on its website and will comply with relevant California requirements regarding publicity.

2. Public Works Projects

   Procurement and award of Public Works Projects will comply with relevant provisions of California statutes, regulations, and other rules regarding Public Works, including rules regarding bonds, prevailing rates, and Department of Industrial Relations registration.

3. Receipt and Review of Offers

   a. Vendor Management will review submissions for responsiveness. Vendor Management will reject submissions that are non-responsive and that cannot be made responsive within timelines set by Vendor Management without disadvantaging another Offeror.

   b. Prior to recommending a contract award, Vendor Management will make a determination of an Offeror's responsibility based on initial information provided in the submission, information submitted upon request, information resulting from inquiry into the Offeror's references and background, and CalOptima Health's own knowledge of the Offeror, taking into consideration matters such as the Offeror's integrity, compliance with public policy, record of past performance, and financial and technical resources. Offerors determined to be non-responsible and who cannot be made to be responsible within timelines set by CalOptima Health will be notified and will not be considered further.

   c. On making a finding of non-responsiveness, Vendor Management will notify the firm or individual. If the firm or individual can demonstrate, within three days, that the materials submitted were in fact responsive, Vendor Management may reconsider the determination.

   d. On making a finding of non-responsibility, Vendor Management will notify the firm or individual and provide three business days to respond. CalOptima Health may accept the response and modify its original determination or may reject the response and notify the respondent. CalOptima Health's decision will be final.

4. Contract Award

   Following a check for responsiveness and responsibility, contracts for price-based solicitations will be awarded to the responsive, responsible individual or firm offering the lowest price, and contracts for best value solicitations such as RFPs will be awarded to the responsive, responsible Offeror that, in the opinion of CalOptima Health, provides the best value.

5. Protests

   a. Protests or objections regarding formal procurements may be filed with Vendor Management regarding the procurement process, solicitation or addendum content, or contract award. CalOptima Health will review only protests submitted by prospective

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or actual Offerors. Protests by prospective or actual subcontractors or uninvolved parties will be rejected.

b. Protests must include detailed grounds for the protest, supported with technical data, documentary evidence, names of witnesses, and other pertinent information related to the subject being protested, and the law, rule, regulation, or policy upon which the protest is based, alleging a clear violation of a specific law, rule, regulation, or policy.

c. Vendor Management will establish procedures for accepting and receiving protests, which will be included in each formal solicitation.

E. Miscellaneous Provisions

1. Real Property Transactions

CalOptima Health may not enter into any transaction for the purchase, sale, license, lease (including any sublease or lease assignment, whether CalOptima Health is the lessor, lessee, sublessor, sublessee, assignor or assignee), or termination of lease of any real property, or enter into negotiations related to such transactions, without the prior approval of the Board, pursuant to a Board action addressed solely to the transaction or set of related transactions that sets forth the parameters under which the negotiations may proceed. Such negotiations and transactions on behalf of CalOptima Health are to be carried out exclusively by the person or persons designated by the Board.

2. Multipurpose Senior Services Program (MSSP) Purchases

Equipment and supplies procured by CalOptima Health with funding from the MSSP waiver are the property of the State of California and must comply with procedures and standards outlined by the State of California. Such purchases under the MSSP do not include equipment and supplies purchased for an individual member, which become the property of the individual member.

3. Information Technology

Contracts for software licenses, software maintenance, or computer equipment must be approved in writing by the Information Technology Services Department.

4. Healthcare Services

For healthcare services contracts that require procurement, the Provider Operations Department will coordinate award with Vendor Management with approval of an appropriate signing party under CalOptima Health Policy GA.3202: CalOptima Health Signature Authority, within limits delegated by the Board and with approval of contract templates (and any deviations) by the Legal Counsel.

F. Contract Modifications and Change Orders

1. General requirements

If a contract modification will result in an increase in the aggregate contract value, a Change Order must be approved by an individual authorized to approve contracts of that amount.

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2. Standard Contracts

   a. Cumulative increases to a contract procured through Informal Procurement may not increase the value of the contract to an amount greater than the Informal Procurement limit.

   b. A contract amendment may not increase the value of a contract by over 30% of the original contract amount, unless:

      i. The value increase is due to price increases in supplies, materials, or labor;

      ii. The need for additional goods or services could not be accurately projected and the percentage of increase does not justify re-soliciting;

      iii. An emergency exists which does not permit re-bidding; or

      iv. The additional amount is due to alternates or options that were contemplated by the original contract.

   c. Contract modifications that materially alter the scope of work or services originally contemplated, and that could not have reasonably been foreseen when the solicitation was released, require a new procurement. If modifications are due to emergency conditions that could not have been foreseen, the modifications must be justified in writing and approved by the Board.

3. Construction Contracts

   a. Modifications and Change Orders that alter the responsibilities of the parties under the contract require amendments.

   b. Modifications to a contract's value due to design errors or omissions, or for additional work, require appropriate price analysis to determine price reasonableness and may not be made if the additional value is not determined fair and reasonable by Vendor Management and the business owner. The determination and methodology must be recorded, provided with any request for a change order, and approved by Vendor Management.

   c. Modifications to renovation or construction contracts that do not increase the contract's value are permitted if the vendor can furnish:

      i. A substantially equal product with a cost savings to the Project; or

      ii. A superior product at the original contract price.

   d. Modifications to renovation or construction contracts that increase the contract value may be permitted if:

      i. The modification fits within the scope of the contract and is required to complete the work contemplated as part of the original scope of the contract; or

      ii. The reason for the change is something that was unanticipated, could not have been foreseen at the time the original contract was awarded, and is necessary to complete the project.

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e. Modifications to renovation or construction contracts may not, individually or in the aggregate, represent significant material deviations from the quality, amount, type, or cost of work originally contemplated by the contract, or require the contractor to perform duties substantially different from those originally bargained for. Modifications that alter the original Scope of Work such that they amount to material changes that result in a fundamental redesign of a project require a new procurement and may require termination of the original contract.

4. Architecture, Engineering, Environmental and Land Surveying Contracts

Architectural, landscape architectural, engineering, environmental, and land surveying services that must be procured by QBS pursuant to Government Code §4525 *et. seq.*, may not be modified to include work that could not have been reasonably contemplated as being within the original scope of services requested, or to include additional projects that were not contemplated within the original scope.

G. Contract Duration

1. The duration of a contract should be commensurate with the type of contract contemplated, the scope and complexity of the subject matter, industry standards, changes or potential changes in technology or market conditions, and the expected time for delivery of the goods and services requested.

2. CalOptima Health may enter into long-term contracts of up to ten years to take advantage of one or more of the following:

a. Lower total costs and better overall ROI, including employee training, amortization of startup and deployment costs, and cancellation charges;

b. Continuity and stability of services and performance;

c. Standardization of CalOptima Health systems; or

d. Compliance with legal requirements.

3. Factors to consider when establishing a long-term contract may include:

a. Time and resources required for replacement and deployment of new systems, procedures, or processes;

b. The scale of risk associated with engaging a replacement contractor;

c. The number of departments affected;

d. Required compatibility with State or federal systems;

e. Whether better pricing would be offered over a longer term;

f. Vendor recoupment of high start-up costs or capital investment over a longer contract period;

g. Infrastructure stability and CalOptima Health's internal technology roadmap;

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h. Requirements that the vendor establish linkages with other vendors;

i. Programs where the population to be served is fragile or difficult to serve and the well-being of the population would be jeopardized by frequent vendor changes;

j. The service provided involves the development and continuity of a personal, supportive, or therapeutic relationship between a caregiver and client is an integral part of treatment and the treatment would be jeopardized by severance of that relationship as a result of vendor change;

k. The services involve funding a center-based facility that requires obtaining permits, approvals, leases, or capital improvements by the service provider.

4. The CalOptima Health Board must approve contracts of over ten years.

III. PROCEDURE

Not Applicable

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. 10 U.S. Code §2306
B. California Fair Political Practices Commission Form 700 - Statement of Economic Interests
C. California Government Code
D. California Public Contract Code
E. CalOptima Health Code of Conduct
F. CalOptima Health Compliance Plan
G. CalOptima Health Conflict of Interest Code
H. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
I. CalOptima Health Policy AA.1216: Solicitation and Receipt of Gifts to CalOptima Health
J. CalOptima Health Policy GA.3202: CalOptima Health Signature Authority
K. CalOptima Health Policy GA.5003: Budget Approval and Budget Reallocation
L. CalOptima Health Resolution No. 12-03101-01
M. Title 2, Code of Federal Regulations (CFR) Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards
N. Title 48, Code of Federal Regulations (CFR) §17.204(e)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

Date	Meeting
11/01/1994	Regular Meeting of the CalOptima Board of Directors
09/10/1996	Special Meeting of the CalOptima Board of Directors
11/04/1997	Regular Meeting of the CalOptima Board of Directors
12/02/1997	Regular Meeting of the CalOptima Board of Directors

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01/11/2000	Regular Meeting of the CalOptima Board of Directors
09/09/2003	Regular Meeting of the CalOptima Board of Directors
03/01/2012	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
09/01/2022	Regular Meeting of the CalOptima Health Board of Directors
05/02/2024	Regular Meeting of the CalOptima Health Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/10/1996	GA.5002	Procurement Policy	Administrative
Revised	11/04/1997	GA.5002	Procurement Policy	Administrative
Revised	12/02/1997	GA.5002	Procurement Policy	Administrative
Revised	01/11/2000	GA.5002	Procurement Policy	Administrative
Revised	01/01/2004	GA.5002	Procurement Policy	Administrative
Revised	03/01/2012	GA.5002	Purchasing Policy	Administrative
Revised	06/07/2018	GA.5002	Purchasing	Administrative
Revised	09/01/2022	GA.5002	Purchasing	Administrative
Revised	05/02/2024	GA.5002	Purchasing	Administrative
Revised	08/01/2025	GA.5002	Purchasing	Administrative

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IX. GLOSSARY

Term	Definition
Bid	An offer to supply goods or services for a specific price.
Capital Project	Acquisition, improvement, modification, or construction of infrastructure assets or equipment that will be used beyond the accounting period in which they are purchased and will be shown as capital assets on financial statements.
Change Order	A post-award modification to a contract that may alter the Scope of Work and may also affect the cost or time for completion of the work.
Confidential Information	All non-public or proprietary information relating to CalOptima Health or a CalOptima Health member designated as confidential or that reasonably should be understood to be confidential given the nature of the information and the circumstances of its disclosure or acquisition.
Formal Procurement	A solicitation method that provides full and open competition in which all responsible parties are allowed to submit competing offers, and that generally includes public advertising of the solicitation.
Informal Procurement	A solicitation method in which, due to the anticipated value of the goods or services solicited, full and open competition and formal advertising is not required and offers may be solicited directly from potential providers of the requested goods or services.
Information Technology	Equipment, hardware, software, systems, and procedures used for acquiring, creating, storing, processing, displaying, or exchanging electronic data.
Micro Purchase	Purchase of goods, non-medical professional services, Public Works projects, capital projects, and computer equipment and telecommunications goods and services estimated to cost less than $50,000.
Offeror	A person or entity submitting a response to a solicitation.
Piggyback	A form of intergovernmental purchasing in which a governmental entity uses (or "piggybacks") on another organization's contract that provides the new user the same pricing and terms as those offered to the original entity.
Public Works	The erection, construction, alteration, repair, or improvement of any public structure, building, or road.
Purchase Order	A document instructing a supplier to deliver goods or services, whether issued independently or under the authority of a contract.
Qualifications-Based Selection ("QBS")	A competitive procurement where design professionals (engineers, land surveyors, architects, etc.) are initially selected based on their qualifications and demonstrated competence, and price is not a factor in the initial evaluation and selection.
Request for Proposals ("RFP")	A solicitation announcing CalOptima Health's interest in obtaining goods or services and inviting interested parties to propose methods of providing those goods or services, where the final selection and contract award will be based on the best overall value to CalOptima Health.
Responsible Bidder/Proposer	A bidder or proposer able to meet all requirements of a solicitation and subsequent contract, possessing or able to obtain the financial and technical capability to perform and to comply with all legal and regulatory requirements, having a history of satisfactory performance, not on a federal or state debarment or suspension list, and generally demonstrating the quality, fitness, capacity, and experience to satisfactorily perform under the anticipated contract.
Responsive Bid/Proposal	A bid or proposal that conforms in all material respects to the requirements of the solicitation.
Scope of Work (SOW)	A description of the detailed requirements of a project, including the objectives, milestones, deliverables, outcomes, management, and the rights and obligations of the parties related to the specific project.
Small Purchase	One-time purchases of goods or services estimated to cost from $50,000 to $250,000.

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CalOptima Health Board Action Agenda Referral

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

Report Item

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

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions

1. Authorize the Chief Executive Officer, or designee, to execute a new Shared Risk Group contract with Providence Medical Foundation for Medi-Cal, effective November 1, 2025.

Background and Discussion

On February 6, 2025, the Board of Directors (Board) approved CalOptima Health staff to pursue a Shared Risk Group (SRG) contract with Providence Medical Foundation (Providence) for the Medi-Cal program. Since that approval, CalOptima Health and Providence staff collaborated to finalize a new SRG contract to improve access and timely coordination of patient care for covered services, enhance member experience, and support CalOptima Health's long-term strategic initiatives.

Under the SRG contract, CalOptima Health Medi-Cal members currently assigned to Providence primary care providers (PCPs) will continue to be assigned to Providence PCPs, unless a member requests assignment to a new CalOptima Health PCP. Providence will continue to provide and coordinate covered services it currently provides to Medi-Cal members assigned to Providence, as well as additional covered services in alignment with its guidelines, mission, and values under a capitated arrangement. Under the SRG contract, CalOptima Health will delegate administrative activities and responsibilities to Providence for the Medi-Cal program, such as utilization management/case management, claims processing, and credentialing/recredentialing and provider contracting, for services that Providence will be financially at risk under the SRG contract.

Providence underwent CalOptima Health's readiness assessment to ensure its compliance with applicable laws, regulations, and CalOptima Health policies. The components of the assessment covered the following areas: program management, paper document control and record retention, data and system security, business continuity and disaster recovery, HIPAA privacy and security, fraud, waste and abuse, and physical compliance. Additionally, the following delegated activities were reviewed against CalOptima Health's readiness audit tools – case management, claims, compliance, customer service, cultural/linguistics, credentialing, information services, and provider network contracting. Providence successfully passed the assessment on June 10, 2025.

Staff requests that the Board approve the recommended action, allowing staff to implement the changes in support of the new SRG contract between CalOptima Health and Providence. The new SRG contract supports CalOptima Health's Fiscal Years 2025-2027 strategic plan and priorities to 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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Fiscal Impact
The Fiscal Year 2025-26 Operating Budget included a new Medi-Cal SRG contract with Providence effective January 1, 2026. The recommended action updates the effective date to November 1, 2025. Staff will monitor and report on any fiscal impact associated with the new SRG contract in the monthly financials.

Rationale for Recommendation
Approval of the recommended action by the Board will allow CalOptima Health to proceed with implementation of the new SRG contract agreed upon by CalOptima Health and Providence.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action
2. Proposed Medi-Cal SRG Contract – Providence Medical Foundation

Board Actions

Board Meeting Dates	Action
February 6, 2025	1. Approve staff pursuing a shared risk group-model health network contract with Providence Medical Foundation for the Medi-Cal program, with a targeted effective no earlier than July 1, 2025.

/s/ Michael Hunn *08/28/2025*
Authorized Signature **Date**

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Attachment to the September 4, 2025 Board of Directors Meeting – Agenda Item 19

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Providence Medical Group	200 W. Center Street, Promenade Suite 300	Anaheim	CA	92805-3960

MEDI-CAL

PHYSICIAN – SHARED RISK

AMENDED AND RESTATED

CONTRACT FOR HEALTH CARE SERVICES

BETWEEN

CALOPTIMA

AND

PROVIDENCE MEDICAL FOUNDATION

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A CALOPTIMA MEDI-CAL DIVISION OF FINANCIAL RESPONSIBILITY

B DISCLOSURE FORM

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D DECLARATION OF CONFIDENTIALITY

E CAPITATION RATES

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E-2 SHARED RISK PROGRAM

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E-4 INTENTIONALLY LEFT BLANK

E-5 INTENTIONALLY LEFT BLANK

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F CERTIFICATION REGARDING LOBBYING – 1&2
G CALIFORNIA REGULATORY REQUIREMENTS
H DELEGATION AGREEMENT

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AMENDED AND RESTATED
CONTRACT FOR HEALTH CARE SERVICES

PHYSICIAN
(Shared Risk)

THIS CONTRACT FOR HEALTH CARE SERVICES ("Contract") is entered by and between Orange County Health Authority, a public agency, dba **CalOptima Health**, ("CalOptima"), and **Providence Medical Foundation** ("Physician"), with respect to the following facts:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance No. 00-8, as a result of the efforts of the Orange County health care community.

B. CalOptima has entered into a contract with the State pursuant to which it is obligated to arrange and pay for the provision of services to Medi-Cal eligible beneficiaries residing in Orange County, California, who receive Covered Services.

C. Physician is a California professional medical corporation, which employs or otherwise contracts with physicians who are physicians licensed to practice medicine in the State of California.

D. Physician desires to provide or arrange for the provision of Covered Services to Members as defined herein.

E. CalOptima and Physician desire to enter into this Contract on the terms and condition(s) set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
Definitions

1.1 "Administrative Services" means those non-clinical functions that are the responsibility of the Physician and are required to discharge the obligations and meet the requirements set forth in this Contract, in CalOptima Policies and in Memoranda of Understanding.

1.2 "Adult Expansion Member" means a Member enrolled in aid codes L1 and M1 as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

1.3 "Advance Directive" means a written instruction such as under the California Natural Death Act Declarations or durable power of attorney for health care, recognized under State law and relating to the provision of medical care when an individual is incapacitated.

1.4 "Aid Code" means the two-character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.

1.5 "American Indian" means a Member who meets the criteria for an "Indian" as stated in 42 CFR 438.14(a), which includes members in a federally recognized Indian tribe, resides in an urban center and meets one or more of the criteria stated in 42 CFR 438.14(a)(ii), is considered by the Secretary

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of the Interior to be an Indian for any purpose, or is considered by the Secretary of Health and Human Services to be an Indian for purpose of eligibility for Indian health services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

1.6 "American Indian Health Care Provider" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

1.7 "American Indian Health Service Programs" means facilities operated with funds from the Indian Health Service under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible American Indian population with a defined geographic area, per Title 22, Section 55000.

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1.9 "California Children's Services (CCS)" means those services authorized by the CCS Program for the diagnosis and treatment of the CCS Eligible Conditions of a specific Member.

1.10 "California Children's Services (CCS) Eligible Condition(s)", means a physically handicapping condition defined in Title 22 CCR Sections 41515.2 through 41518.9.

1.11 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS Eligible Conditions.

1.12 "CCS Provider" or "CCS-Paneled Provider(s)" means any of the following providers when used to treat Members for CCS Eligible Conditions:

A. A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106.

B. A licensed acute care hospital approved by the CCS Program.

C. A special care center approved by the CCS Program.

1.13 "CalOptima Board" or "Board" means the CalOptima Board of Directors.

1.14 "CalOptima Direct" or "COD" means a program CalOptima administers for CalOptima beneficiaries not enrolled with a Health Network or Physician group.

1.15 "CalOptima Policy(s)" means CalOptima policies and procedures relevant to this Contract, as amended from time to time, at the sole discretion of CalOptima.

1.16 "CalOptima's Regulators" means those government agencies that regulate, oversee, or enforces applicable statutory, regulatory, or contractual requirements relating to the activities and/or obligations of CalOptima, Physician, and Subcontractors under the State Contract, this Contract, and Subcontracts, as applicable, including, without limitation, DHCS, the HHS Office of Inspector General, the Comptroller General of the United States, the Department of Justice (DOJ), DOJ Bureau of Medi-Cal Fraud, the Department of Managed Care (DMHC), and other authorized federal or State agencies, or their duly authorized representatives or designees, including DHCS' external quality review organization contractor.

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1.17 "Capitation Payment" means the monthly amount paid to the Physician by CalOptima for delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by Physician's monthly enrollment based upon Aid Code, age and gender.

1.18 "Capitation Rate" means the rate set by CalOptima for the delivery of Covered Services to Members based upon Aid Code, age and gender.

1.19 "Care Management Services" means:

1.19.1 Providing or approving all Covered Services including health assessments, identification of risks, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services;

1.19.2 Coordinating Medically Necessary Covered Services with other Medi-Cal benefits not covered under this Contract;

1.19.3 Maintaining a Medical Record with documentation of referral services and follow-up as medically indicated;

1.19.4 Ordering of therapy, admission to hospitals and coordinated hospital discharge planning that includes necessary post-discharge care;

1.19.5 Authorization of referred services;

1.19.6 Coordinating a Member's care with all external agencies that are required to be involved in addressing the Member's needs as addressed in MOUs and in CalOptima Policies;

1.19.7 Coordinating care for Members transitioning from CalOptima Direct to a Health Network or Physician group or from one Health Network or Physician group to another Health Network or Physician group; and

1.19.8 Targeted services for Members with Special Health Care Needs to support compliance with Federal Medicaid contingencies, including but not limited to: identification of Members with Special Health Care Needs, assessment of Members with Special Health Care Needs, development of treatment plans, and monitoring the progress of adherence to treatment plans for Members with Special Health Care Needs.

1.19.9 Any of the services listed in this Section 1.19 as necessary to coordinate referrals and coordination of care for Members eligible for both Medicare and Medi-Cal services, as required by CalOptima's contracts with DHCS.

1.20 "Child Health and Disability Prevention" or "CHDP" means the California program, defined in the Health and Safety Code Section 12402.5 et seq., that covers certain pediatric preventive services for children eligible for Medi-Cal.

1.21 "Clean Claim" shall have the same meaning as "Complete Claim," as that term is defined in Title 28, CCR Section 1300.71(a)(2).

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1.24 "Complex Case Management" means the systematic coordination and assessment of case and services provided to Members who have experienced a critical event or diagnosis that requires the

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extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes basic case management.

1.25 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors and providers comply with applicable law and ethical standards.

1.26 "Comprehensive Perinatal Services Program" or "CPSP" means those services defined in Section 14134.5 of the Welfare and Institutions Code and Title 22, Sections 51179 and 51348 of the California Code of Regulations (CCR). For CalOptima Members, CPSP is incorporated into CalOptima's Perinatal Support Services (PSS).

1.27 "Concentration Languages" means those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or by at least 1,500 such Members in two contiguous ZIP codes.

1.28 "Contract" means this written instrument between CalOptima and Physician. This Contract shall include, in addition to this document, any Memoranda of Understanding entered into by CalOptima which are binding on Physician, DHCS Medi-Cal Managed Care Policy Division Policy Letters.

1.29 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the State Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, CCS Services (as defined in Subdivision 7 of Division 2 of Title 22, of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

1.30 "DHCS" means the State of California Department of Health Care Services.

1.31 "Derivative Aid Code" means an Aid Code, which is a subset of eligible beneficiaries derived from an original covered Aid Code.

1.32 "Disease Management" means a multi-disciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions:

1.32.1 That supports the physician/patient relationship;

1.32.2 Emphasizes prevention of exacerbation and complications utilizing cost-effective evidence based practice guidelines and patient empowerment strategies such as self-management; and

1.32.3 Continuously evaluates clinical humanistic and economic outcomes with the goal of improving health.

1.33 "Early and Periodic Screening, Diagnostic and Treatment" or "EPSDT" means a comprehensive and preventive child health program for individuals under the age of twenty-one (21). EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental and hearing services. In addition, Section 1905(r)(5)

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of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

1.34 "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1.34.1 Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

1.34.2 Serious impairment to bodily functions; or

1.34.3 Serious dysfunction of any bodily organ or part.

1.35 "Emergency Services" means Covered Services furnished by a qualified Provider which are needed to evaluate or Stabilize an Emergency Medical Condition that is found to exist using a prudent layperson standard.

1.36 "Encounter" means any unit of Covered Service provided to a Member by Health Network or Physician group regardless of Health Network or Physician group reimbursement methodology. These services include any and all services provided to a Member, regardless of the service location or provider, inclusive of out-of-network services, including sub-capitated and delegated Covered Services.

1.37 "Evaluation Services Provider" means a provider of custom wheelchair and seating systems assessment and evaluation services, whether provided in-home or in the provider's facility, designated and contracted to assess and evaluate a Member with Disabilities (MWD)'s needs for custom power wheelchairs and seating systems, or customized modifications to wheelchairs and seating systems.

1.38 "Facility" means any premises:

1.38.1 Owned, leased, used or operated directly or indirectly by or for the Hospital for purposes related to this Contract; or

1.38.2 Maintained by a Subcontractor to provide Covered Services pursuant to an agreement with the Hospital(s).

1.39 "Family Planning" means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes but is not limited to:

1.39.1 Medical and surgical services performed by or under the direct supervision of a licensed physician for the purpose of Family Planning;

1.39.2 Laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or are associated with Family Planning procedures;

1.39.3 Patient visits for the purpose of Family Planning;

1.39.4 Family Planning counseling services provided during a regular patient visit;

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1.39.5 IUD and UCD insertions, or any other invasive contraceptive procedures/devices;

1.39.6 Tubal ligations;

1.39.7 Vasectomies;

1.39.8 Contraceptive drugs or devices;

1.39.9 Treatment for complications resulting from previous Family Planning procedures.

1.39.10 Family Planning does not include services for the treatment of infertility or reversal of sterilization.

1.40 "Federally Qualified Health Center" or "FQHC" means an entity as defined in 42 USC Section 1396d(l)(2)(B).

1.41 "Fee-for-Service" or "FFS" means the reimbursement paid to Providers on a non-capitated basis.

1.42 "Foster Care" means an out-of-home placement for a child either on a temporary or permanent basis.

1.43 "Health Education" means any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health.

1.44 "Health Maintenance Organization" or "HMO" means the health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, (commencing with Section 1340 of the California Health and Safety Code) ("Knox-Keene Act").

1.45 "Health Network" means a physician hospital consortium (PHC), physician group under a shared risk contract, or health care service plan, such as an HMO, as defined in the Knox-Keene Act, and contracted by CalOptima to provide Covered Services to Members.

1.46 "Healthcare Effectiveness Data and Information Set" or "HEDIS" means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

1.47 "HHS" means the United States Department of Health and Human Services.

1.48 "Hospital" means a general acute care hospital licensed under the laws of the State of California and accredited by the Joint Commission, or other Centers for Medicare and Medicaid Services (CMS) deemed accrediting body, and certified for participation under Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act) and having a Hospital Services Contract with CalOptima.

1.49 "Incontinence Supplies" means Medical Supplies used to manage bowel and/or bladder incontinence.

1.50 "Joint Commission" means the Joint Commission for the Accreditation of Health Care Organizations.

1.51 "Long Term Care Facility" means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services, or sub-acute care services.

1.52 "Management Services Organization" or "MSO" means any organization, firm, company or entity providing Administrative Services on behalf of Physician which impact CalOptima Members.

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1.53 "Medi-Cal" is the name for the Medicaid program in the State of California, and "Medicaid" is the program authorized by Title XIX of the Social Security Act and the regulations promulgated thereunder.

1.54 "Medi-Cal Fee Schedule" means the Medi-Cal payment system for reimbursement for physician services in Title 22, CCR, Section 51503.

1.55 "Medi-Cal Managed Care All Plan Letter (APL)" and "Policy Letter (PL)" are the means by which DHCS conveys information or interpretation of changes in policy or procedure at the Federal or State levels. APLs and Policy Letters provide instruction to the contractors about changes in Federal or State law and Regulation that affect the way in which they operate or deliver services to Medi-Cal beneficiaries.

1.56 "Medically Necessary" or "Medical Necessity" means reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per title 22, CCR Section 51303(a) and 42 CFR 438.210(a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and Welfare and Institutions Code Section 14132(v).

1.57 "Medical Record" means any record kept or required to be kept by any Provider that documents all the medical services received by the Member, including without limitation inpatient, outpatient, emergency care, referral requests and authorizations.

1.58 "Medical Screening Examination" or "MSE" means an examination within Physician's capability (including ancillary services routinely available) to determine whether or not an Emergency Medical Condition exists.

1.59 "Medical Supplies" means items, which, due to their therapeutic or diagnostic characteristics, are essential to enable Members to effectively complete a physician ordered plan of care, excluding common household items and clothing.

1.60 "Medical Therapy Program (MTP)" means a special program within California Children's Services that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders.

1.61 "Medicare" means the federal health insurance program for: people sixty-five (65) years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called (ESRD)) as defined in Title XVIII of the Federal Social Security Act.

1.62 "Member" means a Medi-Cal eligible beneficiary as determined by the County of Orange Department of Social Services, DHCS, or the United States Social Security Administration who is enrolled in the CalOptima Program and assigned to Physician.

1.63 "Member with Special Health Care Needs" means a Member who meets at least one of the following criteria: (i) Medicare eligible; (ii) diagnosed with an emotional or physical disability; (iii) placed in the foster care system; (iv) Regional Center of Orange County (RCOC) program eligible; or (v) CCS Program eligible.

1.64 "Memorandum/Memoranda of Understanding" or "MOU" means agreements between CalOptima and external agencies, which delineates responsibilities for coordinating care to Members, and

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contracts between CalOptima and the County of Orange that incorporate such agreements, including but not limited to the Coordination and Provision of Public Health Care Services Contract.

1.65 "Minimum Standards" means the minimum participation criteria established by CalOptima that must be satisfied in order for specified categories of Providers to submit claims and/or receive reimbursement from the CalOptima program (including Health Networks, Physician groups and CalOptima Direct) for items and/or services furnished to Members as described in CalOptima Policies.

1.66 "National Committee on Quality Assurance" or "NCQA" means the non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

1.67 "Other Member" means a Medi-Cal beneficiary as determined by the County of Orange Social Services Agency, DHCS, or the United States Social Security Administration who is enrolled by the State in a CalOptima Program but is not enrolled with Physician.

1.68 "Out-of-Network Provider" means a Provider who is not obligated by a written contract with Physician or Hospital to provide Covered Services to Members.

1.69 "Outpatient Mental Health Services" means outpatient services that CalOptima will provide for members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies and supplements.

1.70 "Participating Provider" means a Provider who is obligated by a written contract to provide Covered Services to Members on behalf of Physician. All Participating Providers shall be considered Subcontractors.

1.71 "Participation Status" means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or has a felony conviction as specified in CalOptima's Compliance Program and CalOptima Policies.

1.72 "Pediatric Preventive Services" or "PPS" means well child services which incorporate services covered under the Medi-Cal CHDP Program and the American Academy of Pediatrics Guidelines for Health Supervision.

1.73 "Perinatal Support Services" or "PSS" means obstetrical services enhanced with those perinatal services that are incorporated in CPSP services and perinatal Care Management for pregnant and post-partum Members.

1.74 "Person-Centered Planning" means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-Centered Planning is an integral part of basic and Complex Case Management and discharge planning.

1.75 "PHC" and "PHCs" means a physician-hospital consortium/consortia.

1.76 "Physician" means a group practice, independent practice association or other formal business arrangement comprised of individuals, each of whom hold an unrestricted license to practice medicine or osteopathy in the state in which they practice, and which participates with a Hospital in a PHC or holds a shared risk contract with CalOptima.

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1.77 "Physician Incentive Plan" means any compensation arrangement between Physician and a physician or physician group designed to motivate physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Members.

1.78 "Practitioner" means a licensed practitioner, including a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine, Doctor of Chiropractic Medicine (DC), and a Doctor of Dental Surgery (DDS) furnishing Covered Services under medical benefits, as described in CalOptima Policies.

1.79 "Preclusion List" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

1.80 "Primary Care Physician" or "PCP" means a physician responsible for supervising, coordinating, and providing initial and primary care to patients and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For SPD and CCS Members "Primary Care Physician" or "PCP" shall additionally mean any clinic or Specialist Physician who is a Participating Provider and is willing to perform the role of the PCP, provided that clinic or Specialist Physician is qualified to treat the required range of conditions of the Member.

1.81 "Provider" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution who furnishes health care items or services.

1.82 "Quality Indicators" means measurable variables relating to a specific clinical or health service delivery area, which are reviewed over a period of time to monitor the process or outcome of care delivered in that clinical area.

1.83 "Reinsurance" means coverage provided by CalOptima and any coverage secured by Physician, which limits the amount of risk or liability for the cost of providing Covered Services.

1.84 "Alcohol Misuse Screening and Counseling" or "AMSC" (formerly referred to as "Screening, Brief Intervention, and Referral to Treatment" or "SBIRT") means services provided by a Primary Care Physician to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol.

1.85 "Sensitive Services" means those services related to Family Planning, sexually transmitted disease (STD), abortion and Human Immunodeficiency Virus testing

1.86 "Shared Risk Pool" means the risk sharing program, described in Attachment E hereto, under which the risk for the provision of Shared Risk Services to Members is shared and allocated between CalOptima and Physician.

1.87 "SPD Member" means Members in Seniors and Persons with Disabilities Aid Codes.

1.88 "Specialist Physician" or "Specialist" means a physician who has completed advanced education and clinical training in a specific area of medicine or surgery.

1.89 "Specialized Durable Medical Equipment" means durable medical equipment that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.

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1.90 "Specialty Mental Health Provider" means a person or entity who is licensed, certified or otherwise recognized or authorized under the State law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program. Specialty Mental Health Providers include but are not limited to clinics, hospital outpatient departments, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, hospitals, and licensed mental health professionals, including psychiatrists, psychologists, licensed clinical social workers, marriage, family and child counselors, therapists and registered nurses authorized to provide Specialty Mental Health Services.

1.91 "Specialty Mental Health Services" means:

1.91.1 Rehabilitative services which include mental health services, medication support services, day treatment intensive services, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facility services;

1.91.2 Psychiatric inpatient hospital services;

1.91.3 Targeted Care Management services;

1.91.4 Psychiatrist services;

1.91.5 Psychologist services; and

1.91.6 EPSDT supplemental specialty mental health services.

1.92 "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and the placenta.

1.93 "State" means the State of California.

1.94 "State Contract" means the written agreement between CalOptima and the State pursuant to which CalOptima is obligated to arrange and pay for the provision of Covered Services to certain Medi-Cal beneficiaries in Orange County, California.

1.95 "Subcontract" means a written agreement entered into by the Physician with a Provider who agrees to furnish Covered Services to Members, or any other organization or person who agrees to perform any administrative function or service for Physician specifically related to fulfilling Physician's obligations to CalOptima under the terms of this Contract.

1.96 "Subcontractor" means a Provider or any organization or person who has entered into a Subcontract with Physician. All delegates are Subcontractors, but not all Subcontractors shall be considered delegates. A delegate means an organization or person that subcontracts with Physician to perform any administrative function or service for Physician specifically related to fulfilling Physician's obligations to CalOptima under the terms of this Contract.

1.97 "Sub-delegation" means the process by which Physician expressly grants, by formal written agreement, to another entity the authority to carry out a function that would otherwise be required to be performed by Physician in order to meet its obligations under, and the intent of this Contract.

1.98 "Threshold Languages" means those languages as determined by State requirements per MMCD Policy Letter 99-03, APL 17-011, or any update or revision thereof.

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1.99 "Urgent Care Services" means Covered Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury for which treatment cannot be delayed.

1.100 "Vaccines for Children" or "VFC" means the federal program, which provides free vaccines for eligible populations. Medi-Cal covered children, ages eighteen (18) years and younger, are eligible for free vaccines under this program.

1.101 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

1.102 Intentionally Left Blank.

1.103 Intentionally Left Blank.

1.104 Intentionally Left Blank.

1.105 Intentionally Left Blank.

1.106 "Basic Case Management" or "Basic PHM" means CalOptima's approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's risk tier, at the right time and in the right setting. Basic PHM includes federal requirements for care coordination and comply with all applicable federal and state requirements, and National Committee for Quality Assurance ("NCQA") standards.

1.107 "Enhanced Care Management" or "ECM" means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, high-touch, and person-centered. ECM is a Medi-Cal benefit.

1.108 "ECM Care Team" means a team of staff employed or contracted by the Physician, as an ECM Provider, that provides ECM services to ECM Members.

1.109 "ECM Member" means a CalOptima Medi-Cal Member who meets inclusion criteria for one of the ECM Populations of Focus, authorized to receive ECM services, and assigned to the Physician.

1.110 "ECM Provider" means Physician when providing ECM services to ECM Members pursuant to this Contract.

1.111 "Community Supports means, as set forth in 42 CFR § 438.3(e)(2), services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to the State Plan Covered Services. Community Supports are optional for both CalOptima and the Member and must be approved by DHCS. Effective no sooner than January 1, 2022, CalOptima shall offer the following four (4) selected DHCS-approved Community Supports, as further defined in CalOptima Policy GG.1355: Community Supports: (i) Housing Transition Navigation Services; (ii) Housing Deposits; (iii) Housing Tenancy and Sustaining Services; and (iv) Recuperative Care (Medical Respite).

1.112 "Lead Care Manager" means a Member's designated care manager for ECM, who works for the ECM Provider organization. The Lead Care Manager operates as part of the Member's ECM Care Team and is responsible for coordinating all aspects of ECM and any Community Supports. To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.

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1.113 "Targeted Rate Increase" or "TRI" means the set of provider rate increases authorized by Assembly Bill 118 (Chapter 42, Statutes of 2023) as implemented by DHCS. The TRI applies to eligible network providers, as defined by DHCS. The first phase of TRIs are effective for dates of service beginning January 1, 2024. For services on the Medi-Cal TRI fee schedule from eligible network providers, CalOptima and its delegates, including Physician and its Subcontractors, must pay the greater of the DHCS published TRI fee schedule or the then current contractual rates inclusive of any Proposition 56 supplemental payment previously due to provider. The TRI applies to both fee-for-service and other provider payment arrangements such as capitation payments. In the case of capitation and other prospective payment arrangements, the expected fee-for-service equivalency of those rates must be the same or greater than the TRI fee schedule rate.

1.114 "Ethical and Religious Directives" means the Ethical and Religious Directives for Catholic Health Care Services published by the United States Conference of Catholic Bishops.

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ARTICLE 2
Obligations of Physician – Financial

2.1 FINANCIAL SECURITY REQUIREMENTS --- Physician must establish and maintain, throughout the term of this Contract, financial security reserves, in the form of time certificates of deposit, irrevocable standby letters of credit, surety bonds naming CalOptima as beneficiary, and/or other forms of financial instruments acceptable by CalOptima, equal to plus a minimum of twenty-five percent (25%) of one month's Capitation Payment. Physician shall have thirty (30) days upon receiving notice from CalOptima to cure any deficit.

2.2 INDEMNIFICATION --- Each party to this Contract agrees to defend, indemnify and hold each other and the State harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or willful performance or non-performance by the indemnifying party, or any functions, duties or obligations of such party under this Contract. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

2.3 INSURANCE REQUIREMENTS---

2.3.1 Professional/Medical Malpractice:
Each Participating Provider providing Covered Services to Members shall maintain a Professional Liability (Medical Malpractice) Insurance policy for the specialty or type of service which the Participating Provider provides with minimum limits as follows:

PCP or Specialist Physician:
$1,000,000 per incident/$3,000,000 aggregate

2.3.2 Commercial General Liability/Commercial Automobile Liability:
Physician shall maintain a Commercial General Liability Insurance policy and a Commercial Automobile Liability Insurance policy with minimum limits as follows:

Commercial General Liability:
$1,000,000 per occurrence/$3,000,000 aggregate
Commercial Automobile Liability:
$1,000,000 Combined Single Limit

CalOptima must be named as an additional insured on Physician's Comprehensive General Liability and Automobile Liability insurance with respect to performance under this Contract.

2.3.3 Workers' Compensation:
Physician and each Participating Provider shall maintain a Workers' Compensation Insurance policy with minimum limits as follows:

Employers' Liability Insurance:
$1,000,000 Bodily Injury by Accident - each accident
$1,000,000 Bodily Injury by Disease - policy limit
$1,000,000 Bodily Injury by Disease - each employee

2.3.4 Managed Care Errors and Omissions:
Physician shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

Managed Care Errors and Omissions:
$5,000,000 each claim/$5,000,000 aggregate

2.3.5 Cyber Liability:
Physician shall maintain cyber lability insurance with the minimum limits listed below covering first and third-party claims involving privacy violations, data breaches, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion, and network security. Such coverage shall provide for costs of legal fees, forensic expenses, regulatory fines and penalties, notification expenses, credit monitoring and ID theft repair, public relations expenses, and costs of liability and defense.

Cyber Liability Insurance:

$5,000,000 each occurrence/claim and $5,000,000 aggregate

2.3.6 Insurer Ratings: Such insurance shall be provided by an insurer:

(a) Rated by A.M. Best with a rating of A V or better; and
(b) "Admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or licensed as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code § 12180.7.

2.3.7 Captive Risk Retention Group/Self Insured: Where any of the Insurance(s) mentioned in this Section 2.3.7 are provided by a Captive Risk Retention Group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only after review of the Captive Risk Retention Group's or self-insured's audited financial statements.

2.3.8 Cancellation or Material Change: The Shared Risk Group shall not of its own initiative cause such insurance as addressed in this Article to be cancelled or materially changed during the term of this Contract.

2.3.9 Proof of Insurance: Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance maintained by Physician shall be provided to CalOptima prior to execution of the Contract and annually thereafter. Physician shall provide the

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Certificates of Insurance of the above Insurance policies and/or evidence of self-insurance maintained by Participating Providers to CalOptima upon request.

2.4 REIMBURSEMENT FOR CERTAIN COVERED SERVICES PROVIDED BY LOCAL HEALTH DEPARTMENT --- Physician shall reimburse the Local Health Department (LHD) on a FFS basis, according to the current Medi-Cal Fee Schedule, for certain Covered Services provided to Members, in accordance with CalOptima Policy. This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.5 PHYSICIAN FINANCIAL RESPONSIBILITY FOR MEDICAL SUPPLY ITEMS --- Physician shall be responsible for authorizing all injectable medications, or medications in an implantable dosage form which shall be reimbursed as set forth in Attachment A, Division of Financial Responsibility.

2.5.1 AS SET FORTH IN ATTACHMENT A, the Division of Financial Responsibilities, Physician shall also be financially responsible for authorizing and paying for Medical Supplies and durable medical equipment with the exception of certain Medical Supplies as set forth in Attachment C.

2.5.2 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.6 Not Applicable to this Contract.

2.7 PHYSICIAN PAYMENTS TO PROVIDERS ---

2.7.1 Capitation Payments - Physician and/or Subcontractors shall distribute monthly capitation payments to capitated Participating Providers within fifteen (15) calendar days following the date on which Physician receives payment from CalOptima.

2.7.1.1 Physician shall evaluate and adjust as necessary its capitation payments to Participating Providers that provide TRI-eligible services to ensure such capitation payments meet the TRI requirements. If adjustment to Participating Provider capitation payments is necessary, Physician shall adjust such capitation payments retroactive to January 1, 2024, by no later than December 1, 2024. Physician's reimbursement for TRI-eligible services shall comply with DHCS requirements, Laws, and CalOptima Policies.

2.7.2 Claims Turnaround Time - Physician shall reimburse Complete Claims, or any portion of any Complete Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by Physician, unless the claim or portion thereof is reasonably contested by Physician, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by Physician in accordance with CalOptima Policy.

2.7.3 Claims Adjudication – Except as provided in this Section, Physician shall accept and adjudicate claims for Covered Services provided to Members in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

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2.7.4 Dispute Resolution - Physician shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the California Code of Regulations and CalOptima Policies.

2.7.5 Right Of Appeal - Physician shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to Physician's dispute resolution mechanism involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from Physician's Date of Determination.

2.7.6 CalOptima Payment On Behalf Of Physician

2.7.6.1 If CalOptima receives a copy of an unpaid Complete Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies.

2.7.6.2 If Physician does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Complete Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of Physician, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation payment, in accordance with CalOptima Policy.

2.7.7 Assumption of Delegated Functions.

2.7.7.1 Assumption Of Claims Processing. In the event that Physician fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, either assume responsibility from Physician for claims payment, or terminate this Contract as provided for in Section 13.1 of this Contract. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that Physician has established an approved corrective action plan consistent with Section 1375.4 (b)(4) of the Health and Safety Code.

2.7.7.2 Assumption Of Dispute Resolution. In the event that Physician fails to resolve its Provider disputes in a timely manner, CalOptima may, at its sole discretion, assume responsibility from Physician for dispute resolution, or terminate this Contract as provided for in Section 13.1 of this Contract.

2.7.7.3 Recoupment Of Costs For Assumption Of Claims Processing And/Or Dispute Resolution. CalOptima, at its sole and absolute discretion, may reduce Physician Capitation Rate to recoup additional administrative costs for the assumption of the claims processing and/or dispute resolution responsibilities of Physician, as described in this Section, as well as any amounts, including interest due, on claims unpaid at the assumption of responsibilities by CalOptima.

2.7.8 Quarterly Claims Payment Performance Report.

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2.7.8.1 Physician shall submit, in a format specified by CalOptima Policies, a Quarterly Claims Payment Performance Report ("Quarterly Claims Report") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose Physician's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4 and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the California Code of Regulations.

2.7.8.2 Physician shall ensure that each Quarterly Claims Payment Performance Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the California Code of Regulations, of Physician, stating that the report is true and correct to the best knowledge and belief of the principal officer.

2.7.8.3 Physician's Quarterly Claims Payment Performance Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

2.7.9 Forwarding of Misdirected Claims

2.7.9.1 Physician shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the physician group. Physician will receive misdirected claims per CalOptima Policy.

2.7.9.2 Physician shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within 10 working days of receipt of the claim. CalOptima shall receive these files per CalOptima Policy and load them into their system to ensure timely claims processing.

2.7.10 FQHC Payments – If FQHC, Physician shall reimburse the FQHC at a rate comparable to any other Subcontract arrangement for similar services.

2.7.11 American Indian Health Service Payments - Physician shall reimburse American Indian Health Care Provider(s) for Covered Services provided to Members who are qualified to receive services from an American Indian Health Care Provider. Physician shall reimburse the American Indian Health Care Provider at a rate comparable to any other Subcontract arrangement for similar services.

2.7.12 Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Payments - If there are no CNMs or CNPs in Physician's provider network, Physician shall reimburse non-contracting CNMs or CNPs for services provided to Members at no less than one hundred percent (100%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy.

2.7.13 Intentionally Left Blank -

2.7.14 Sexually Transmitted Disease Treatment Payments - Physician shall reimburse local health departments and non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as consistent with DHCS requirements and

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CalOptima Policy, for the diagnosis and treatment of a STD episode, as defined in MMCD Policy Letter No. 96-09. Physician may elect to provide reimbursement only if STD treatment providers provide treatment records or documentation of the Member's refusal to release Medical Records to Physician along with billing information.

2.7.15 HIV Testing and Counseling Payments - Physician shall reimburse local health departments and non-contracting family planning providers at no less than one hundred percent (100%) of the Medi-Cal fee schedule as consistent with DHCS requirements and CalOptima Policy. Physician shall provide reimbursement only if local health departments and non-contracting family planning providers make all reasonable efforts, consistent with current laws and regulations, to report confidential test results to Physician.

2.7.16 Information Disclosures To Participating Providers Physician shall provide to all Participating Providers, initially upon contracting and annually thereafter on or before the Contract anniversary date, and at any time upon request from a Participating Provider, in an electronic format as defined and detailed in CalOptima Policies, the following:

2.7.16.1 A complete fee schedule.

2.7.16.2 Payment policies and nonstandard coding methodologies used to adjudicate claims.

2.7.17 Provider Payments –

2.7.17.1 Physician shall reimburse contracted Specialist Physician for Covered Services rendered to Members on an aggregate basis, at an amount equal to or greater than of the Medi-Cal fee schedule except for those members specified below.

2.7.17.2 In addition to the requirements in this Contract, effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall compensate CCS paneled physicians and surgeons providing CCS Services to CCS eligible Members at rates that are equal to or exceed the applicable Medi-Cal Program CCS fee-for-service rates, unless the physician or surgeon enters into an agreement on an alternative payment methodology mutually agreed to by Physician and the physician and surgeon.

2.7.17.3 By no later than July 31, 2024, Physician shall implement the DHCS-mandated TRI to its fee-for-service provider payments that qualify for the TRI retroactive to dates of service rendered on or after January 1, 2024. If adjustment to fee-for-service provider payments is necessary, Physician shall adjust such fee-for-service provider payments retroactive to January 1, 2024, by no later than October 31, 2024. If a rate in an agreement between Physician and a Participating Provider for a TRI-eligible service is less than the Medi-Cal TRI fee schedule, the Medi-Cal TRI fee schedule shall control. Physician's reimbursement for TRI-eligible services shall comply with DHCS requirements, Laws, and CalOptima Policies.

2.7.18 DIRECTED PAYMENTS FOR QUALIFYING COVERED SERVICES --- Effective July 1, 2020, CalOptima and Physician shall administer directed payments that are relevant to this Contract in accordance with CalOptima Policy FF.2011, Directed Payments, including, without limitations, directed payments, such as those described in Attachment E-3, by Physician to eligible providers rendering qualifying Covered Services, reporting requirements related to directed payments, and reimbursement of directed payments by CalOptima to Physician.

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2.7.19 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.8 THIRD PARTY TORT LIABILITY/ESTATE RECOVERY --- Physician shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Physician shall inform CalOptima of potential third party liability claims, and provide information relative to potential third party liability claims, in accordance with CalOptima Policy.

2.9 OTHER HEALTH COVERAGE (OHC) --- Physician shall cost avoid or make post-payment recovery for the reasonable value of Covered Services paid by Physician and rendered to Members whenever a Member's OHC covers the same Covered Services, either fully or partially. In no event shall Physician cost avoid or seek post-payment recovery for the reasonable value of Covered Services from a Third Party Tort Liability Action or make a claim against the estates of deceased Members. Physician shall coordinate benefits with other programs or entitlements recognizing OHC as primary coverage and Medi-Cal as the payor of last resort. Physician shall not undertake cost avoidance or post-payment recovery except on the basis of OHC reflected in an OHC code reflected in the Medi-Cal eligibility records.

2.9.1 Cost Avoidance - If Physician reimburses a Provider on a Fee-for-Service basis, Physician shall not pay claims for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code without proof that the Provider has first exhausted all benefits of other liable parties. Proof of third party billing is not required before payment for services provided to Members with OHC codes A or N.

2.9.2 Post-Payment Recovery - If Physician reimburses a Provider on a Fee-for-Service basis, Physician shall pay the Provider's claims and then seek to recover the cost of the claim by billing liable third parties for services provided to Members with OHC codes A or N; for services defined by DHCS as prenatal or PPS; or in child support enforcement cases. If Physician does not have sufficient information to determine whether or not OHC is the result of child support enforcement case, then Physician shall follow the procedure above for cost avoidance. If Physician does not reimburse a Provider on a Fee-for-Service basis, then Physician shall pay for Covered Services to a Member whose Medi-Cal eligibility indicates third party coverage, designated by an OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual Covered Services rendered.

2.9.3 Physician shall have written policies implementing these requirements.

2.9.4 Physician shall submit monthly reports to CalOptima identifying OHC in accordance with CalOptima Policies.

2.9.5 Physician shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. Reports shall be made available upon CalOptima request.

2.9.6 Physician shall identify OHC unknown to DHCS within ten (10) days of discovery to CalOptima in accordance with CalOptima Policies.

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2.9.7 Physician shall demonstrate to CalOptima that where Physician does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues Physician projects it would receive from such activity.

2.9.8 This Section shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

2.10 MEDICAL LOSS RATIO --- Physician shall maintain a minimum acceptable medical loss ratio as defined by CalOptima Policies of eighty-five percent (85%) when combined with the revenues and expenses of the Shared Risk Pool, which are identified in Attachment E.

2.11 FINANCIAL VIABILITY STANDARDS AND REPORTING --- Physician shall maintain a cash-to-claims ratio of no less than .75 at all times during this Contract. Physician shall substantiate compliance with this requirement by submitting all applicable reports to the Department of Managed Health Care that are required under Section 1300.75.4.2 of Title 28 of the California Code of Regulations.

2.12 COOPERATION WITH DMHC --- Physician shall fully cooperate and comply with the Department of Managed Health Care's review and audit process, and permit DMHC to obtain and evaluate supplemental financial information related to Physician, in accordance with Section 1300.75.4.7 of Title 28 of the California Code of Regulations. Physician shall also fully cooperate and participate in DMHC's Corrective Action Plan (CAP) process, in accordance with Section 1300.75.4.8 of Title 28 of the California Code of Regulations.

2.13 Not Applicable to this Contract.

ARTICLE 3
Obligations of Physician - Administrative

3.1 Not Applicable to this Contract.

3.2 EQUAL OPPORTUNITY

3.2.1 Physician and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Physician and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Physician and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Physician and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

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3.2.2 Physician and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Physician and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

3.2.3 Physician and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Physician and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

3.2.4 Physician and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

3.2.5 Physician and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

3.2.6 In the event of Physician and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Physician and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

3.2.7 Physician and its Subcontractors will include the provisions of Sections 3.2.1 through 3.2.7 in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Physician and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of

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enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Physician and its Subcontractors become involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Physician and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

3.3 MARKETING GUIDELINES --- Physician shall comply with the marketing guidelines set forth in CalOptima Policies.

3.4 CALOPTIMA LOGO --- Physician shall not display the CalOptima logo on any Physician's written communication to Members without prior approval by CalOptima.

3.5 MEMBER INQUIRIES AND CALLS --- Physician shall establish and maintain a call center for receiving and responding to Member inquiries and calls. Physician's call center shall meet requirements established by CalOptima Policies. Physician shall equip and furnish call center including but not limited to appropriate telephone equipment and systems, so as to assure Physician will be able to supply call center reports as required by CalOptima Policies.

3.6 WRITTEN MATERIALS --- Except as otherwise provided in this Contract, Physician shall ensure that all written Member information provided by Physician to Members is provided at a sixth grade reading level, or as determined appropriate through the CalOptima group needs assessment and approved by DHCS. The written Member information shall ensure Members' understanding of the health plan covered services, processes and ensure the Member's ability to make informed health decisions. Written Member informing materials shall be translated into the identified Threshold and Concentration Languages. Written Member informing materials shall be provided in alternative formats (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested. Physician shall establish policies and procedures to enable Members to make a standing request to receive all informing material in a specified alternative format.

3.7 COMPLAINTS AND GRIEVANCES ---

3.7.1 Member Grievance Procedures - Members or Members' authorized representative may file grievances about any aspect of service delivery provided or arranged by a Physician. Physician shall implement and comply with CalOptima Policies relating to Member grievances. Physician shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

3.7.2 Provider Grievance Procedures - Providers may file grievances about any aspect of service delivery provided or arranged by Physician. Physician shall implement and comply with CalOptima Policies relating to Provider grievances.

3.8 SUB-DELEGATION AND SUBCONTRACTING OF ADMINISTRATIVE SERVICES. Except as otherwise limited by the State Contract, this Contract and/or CalOptima Policies and subject to CalOptima's prior written approval, Physician may sub-delegate to an MSO, medical group, and/or IPA administrative functions required of Physician but shall not absolve Physician of oversight responsibilities. All sub-delegation must be approved by CalOptima. Physician shall obtain approval of sub-delegation from CalOptima pursuant to the process detailed in CalOptima Policies. Physician's sub-delegation to another entity does not alter Physician's ultimate obligation and responsibilities set forth in this Contract. Physician may give a sub-delegate the authority to act on behalf of Physician; but Physician retains oversight and accountability for the sub-delegated function. Accountability means that Physician cannot abdicate responsibility for the function being

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performed according to the requirements of this Contract, Physician's standards and those established by this Contract and CalOptima Policies. Physician is accountable for all functions performed in its purview whether by Physician, by any sub-delegate or by any sub-sub-delegate. If Physician chooses to sub-delegate a function, Physician must demonstrate that it has not compromised its ability to evaluate structures and processes and to achieve required performance across its Membership and provider network. At a minimum, Physician shall provide CalOptima no later than one hundred twenty (120) days prior to the proposed effective date of the sub-delegation, with written evidence of the sub-delegation including:

3.8.1 A copy of the written agreement which meets the requirements of this Section and which describes the relationship between the Provider and the sub-delegate entity including the following information:

3.8.1.1 The sub-delegated functions;

3.8.1.2 The responsibilities of the Physician and the sub-delegate entity;

3.8.1.3 The frequency of the sub-delegate entity's performance;

3.8.1.4 The process by which the Physician evaluates the sub-delegate entity's performance; and

3.8.1.5 The Physician's remedies if the sub-delegate entity fails to fulfill its obligations including revocation of the sub-delegation.

3.8.2 A description of the Physician's process by which the sub-delegate entity was evaluated and selected to perform the sub-delegated functions, including the entity's score on a selection tool (if any).

3.8.3 A record of the Physician's ongoing oversight process, as requested by CalOptima including:

3.8.3.1 The Physician's annual evaluation of whether the entity is performing the sub-delegated functions in accordance with this Contract and NCQA standards;

3.8.3.2 The Physician's review of the sub-delegate entity's regular reports; and

3.8.3.3 Reports and data required to be submitted to CalOptima.

3.8.4 Physician shall terminate as soon as practical to meet the health care needs of Members, upon receiving written notification from CalOptima, any sub-delegation that fails to meet standards established by CalOptima and/or any of the requirements in this Contract or in CalOptima Policies.

3.8.5 Physician shall report to CalOptima in accordance with all requirements established in this Contract and in CalOptima Policies, data and information that includes and encompasses all of Physician's Members, including those receiving services from a sub-delegate of Physician.

3.8.6 Physician shall oversee and monitor its sub-delegates, and audit sub-delegates no less than once in any twelve (12) month period. Physician shall establish standards and performance requirements for the sub-delegate function(s) and requirements for sub-delegates shall require sub-delegate to meet or exceed all requirements of Physician in this Contract and in CalOptima Policies. Physician may be exempt from oversight, monitoring and auditing of sub-delegate if the sub-delegate is:

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3.8.6.1 Contracted directly with CalOptima as a Health Network or Physician group, or as a participant in a Health Network (i.e. a Shared Risk Group, PHC Physician Group or PHC Hospital), or

3.8.6.2 NCQA accredited or certified for the function(s) sub-delegated by Physician to sub-delegate.

3.8.7 Sub-delegates failing to meet performance requirements shall be placed on a Corrective Action Plan (CAP). The CAP shall detail sub-delegate's deficiencies; list specific steps, tasks and activities to bring sub-delegate into compliance; and a timeline for completion of corrective action and to achieve compliance with performance requirements. Physician shall notify CalOptima of any sub-delegate providing services to CalOptima Members that is on a CAP. Physician shall provide CalOptima a copy of the CAP if requested.

3.9 SUBCONTRACTS --- Physician may Subcontract for certain functions covered by this Contract subject to the requirements of this Contract. Physician is required to ensure that all Subcontracts are in writing and include any general requirements of this Contract and all provisions required by this Contract to be incorporated into Subcontracts. Physician is required to inform CalOptima of the name and business addresses of all Subcontractors and notify CalOptima of any changes in Subcontractors within thirty (30) days of execution or change of Subcontract. Physician shall have policies and procedures addressing Subcontracts with any offshore individual or entity that receives, processes, transfers, handles, stores, or accesses CalOptima Member Protected Health Information (PHI) ("Offshore Subcontracts"), including policies that address security of such PHI and CMS requirements for reporting information about Offshore Subcontracts. Physician shall annually complete the CalOptima Offshore Attestation and make its Offshore Subcontract policies and list of such Offshore Subcontracts available to CalOptima upon request, including for audits by CalOptima and/or CalOptima's Regulators. Additionally, Physician shall require all Subcontracts contain the following:

3.9.1 An agreement to make all premises, facilities, equipment, books records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for an audit, inspection, evaluation, examination or copying in accordance with Sections 3.18 to 3.20 of this Contract;

3.9.2 An agreement to maintain such books and records in accordance with any record requirements in this Contract and CalOptima Policies, and for the establishment and maintenance of and access to Medical and Administrative Records as set forth in Sections 3.17 to 3.22 of this Contract;

3.9.3 Requirements for cultural and linguistic sensitivity and provision of interpreter services to be provided as set forth in Sections 3.33 and 3.34 of this Contract;

3.9.4 An agreement to submit provider data, encounter data, and reports relating to the Subcontract in accordance with Sections 7.2, 7.10 and 7.11 of this Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Sections 3.21 and 3.21.1 of this Contract;

3.9.5 An agreement to maintain and make available to DHCS, CalOptima, and/or Physician, upon request, all sub-subcontracts relating to the Subcontract, and to ensure that all sub-subcontracts are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 3.45 of this Contract;

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3.9.6 An agreement requiring compliance with any MOU entered into by CalOptima, which are binding on Physician;

3.9.7 An agreement requiring Subcontractors to provide Covered Services to CalOptima Members in a non-discriminatory manner;

3.9.8 An agreement to comply with all provisions of this Contract with respect to providing Emergency Services, and State Contract (Exhibit A, Attachment 8, Provision 12) for those Subcontractors at risk for non-contracting Emergency Services;

3.9.9 An agreement that Subcontractors shall notify Physician of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent;

3.9.10 An agreement to comply with (a) CalOptima's Compliance Program including, without limitation, CalOptima Policies; (b) any DHCS Medi-Cal Provider Bulletins and Manuals; (c) all applicable requirements of the DHCS Medi-Cal Managed Care Program, including, but not limited to, the Medi-Cal Managed Care Division Policy Letters and All Plan Letters; and (d) all applicable requirements specified in the State Contract and subsequent amendments, and federal and State laws and regulations;

3.9.11 An agreement that Participating Providers comply with the CalOptima Approved Drug List.

3.9.12 An agreement requiring Subcontractors to sign a Declaration of Confidentiality, which shall be signed and filed with DHCS prior to the Subcontractors being allowed access to computer files or any other data or files, including identification of individual Members;

3.9.13 An agreement to hold harmless the State, Members and CalOptima, in the event Physician cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.1.9 of this Contract;

3.9.14 An agreement to assist and cooperate with Physician and/or CalOptima in the transfer of care of a Member in the event of termination of the State Contract, Contract, or Subcontract for any reason in accordance with Sections 8.2 and 8.2.1 of this Contract.

3.9.15 In the event that Physician implements and maintains a Physician Incentive Plan, it shall ensure that: (A) no specific payment is made directly or indirectly under the incentive plan to a Physician or Physician group as an inducement to reduce or limit Medically Necessary Covered Services provided to an individual Member; and (B) the stop-loss protection (reinsurance), beneficiary survey, and disclosure requirements of 42 CFR § 417.479, 42 CFR § 422.208, and 42 CFR § 422.210 are met by Physician.

3.9.16 Subcontractor shall comply with all monitoring provisions of this Contract and the State Contract and any monitoring requests by CalOptima and DHCS.

3.9.17 Services to be provided by the Subcontractor, term of the Subcontract (beginning and end dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor;

3.9.18 Subcontract or its amendments are subject to DHCS approval as provided in the State Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract;

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3.9.19 An agreement (a) that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 14.10 of this Contract, and (b) to notify DHCS in a manner provided in Section 8.4 of the Contract in the event the Subcontract is amended or terminated;

3.9.20 An agreement to participate and cooperate in quality improvement systems as set forth in Section 6.4 of the Contract, and if Physician delegates quality improvement activities to the Subcontractor, the Subcontract must include the requirements set forth in the State Contract (Exhibit A, Attachment 4, Provision 6), and Sections 3.8 and 6.4 of the Contract, including the Delegation Acknowledgement and Acceptance Agreement ("Delegation Agreement");

3.9.21 An agreement to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies, in accordance with Section 3.46 of this Contract, in instances where DHCS, CalOptima, and/or Physician determines that the Subcontractor has not performed satisfactorily;

3.9.22 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Sections 6.11.9 and 14.12 of the Contract;

3.9.23 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 10.10 of this Contract;

3.9.24 An agreement by the Physician to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 13.12 of the Contract; and

3.9.25 An agreement that Participating Providers are entitled to the protections of the Health Care Provider's Bill of Rights, California Health and Safety Code section 1375.7, in the administration of the Subcontract relative to the Medi-Cal program; and

3.9.26 Subcontractor's agreement to provide Physician with the disclosure statement set forth in 22 CCR Section 51000.35, prior to commencing services under the Subcontract, which shall be provided to CalOptima upon request.

3.10 PHYSICIAN ORGANIZATION AND OPERATIONS STRUCTURE --- Physician shall comply with the following organization and operations structure requirements:

3.10.1 Single Board of Directors and management team.

3.10.2 Medical Director/CMO providing full time coverage. Duties shall include:

- Ensuring that medical decision are:
  - Rendered by qualified medical personnel
  - Are not unduly influenced by fiscal or administrative management considerations.
- Ensuring that the medical care provided meets the standards for acceptable medical care.
- Ensuring that medical protocols and Standards of Conduct for medical personnel are followed.
- Developing and implementing medical policy.

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- Resolve grievances related to medical quality of care.
- Have a role in the implementation of Quality Improvement activities.
- Actively participate in the functioning of the grievance procedures.
- Actively participate in Quality activities including Credentialing and Peer Review.
- Acts as liaison and participates with CalOptima in any activities related to Medical Director/CMO duties.

PHYSICIAN shall report to CalOptima any changes in the status of its Medical Director within ten (10) calendar days.

3.10.3 No employee of Physician, including but not limited to Medical Director(s) and/or the Chief Medical Officer, that make decisions regarding the authorization and/or provision of Covered Services to Members shall have a financial incentive or otherwise benefit financially from decisions made regarding authorization and/or provision of Covered Services to Members, nor shall such an employee have any fiscal or administrative duties or responsibilities that may unduly influence medical judgments.

3.10.4 Single Credentialing Committee and credentialing policies, procedures and standards.

3.10.5 Single and unified health care delivery system including but not limited to:

3.10.5.1 Participating Providers must be accessible to all members enrolled with Physician.

3.10.5.2 Members can select any contracted PCP with an open panel.

3.10.5.3 A PCP can refer members to any contracted specialist.

3.10.5.4 Physician must report to CalOptima all required data for the total enrollment of the Physician and the total provider network regardless of sub-delegation or other contractual relationships including but not limited to; complaints, encounter data, utilization management data, financial reports, PCP changes and PCP assignments.

3.10.5.5 Centralized call center receiving all member and provider calls.

3.10.5.6 Single access number to call center.

3.10.5.7 Standard member communication for all members.

3.10.6 Other organization and operations structure requirements as may be established and modified from time to time by CalOptima.

3.11 ENROLLMENT --- Physician shall accept as Members all persons indicated by CalOptima's information system and through regular transmission from CalOptima to Physician.

3.12 PCP ASSIGNMENT --- Physician shall assign Members who have been automatically assigned to Physician by CalOptima to a PCP within seven (7) days of the Member's assignment to Physician.

3.13 REQUIRED ENROLLMENT INFORMATION AND NOTICE ---Physician shall mail to a Member or Member's head of household a notice of enrollment and a Physician Member handbook

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or CalOptima approved supplement to the CalOptima Member handbook no later than seven (7) calendar days after receipt of notification that a Member has been enrolled with Physician. All member handbooks and supplements prepared by Physician shall be submitted to CalOptima for approval prior to printing. Physician shall not distribute to Members materials not approved by CalOptima. All materials shall be professionally produced and presented.

3.13.1 Should Physician choose to utilize the CalOptima Member handbook, Physician-specific information on each topic as defined by CalOptima Policies must be included in a CalOptima approved supplement to the CalOptima Member handbook given to all Physicians' CalOptima Members. CalOptima shall provide Physician with a template for the supplement to the CalOptima member handbook.

3.13.2 If Physician chooses to produce and use a Member handbook other than the CalOptima Member handbook, in addition to the requirements in this Contract, Physician's Member handbook shall contain all information included in the CalOptima Member handbook and Physician-specific information on each topic as defined by CalOptima Policies.

3.13.3 Physician shall provide Members with periodic updates, as needed, explaining changes in the above policies or services. CalOptima shall approve all updates prior to printing. Physician shall also provide one (1) copy of its enrollment information including its Physician Member handbook or supplement to every Participating Provider.

3.14 SPECIAL DISENROLLMENT --- Physician may request and CalOptima may approve according to CalOptima Policies disenrollment for specific Members.

3.15 VOLUNTARY DISENROLLMENT --- All Members have the right to disenroll from Physician. CalOptima shall process Member disenrollment in accordance with CalOptima Policies.

3.16 ADDITIONAL SERVICES --- Physician shall not solicit enrollment through the offer of any compensation, reward, or benefit to the Member except for additional health-related services, which have been approved by CalOptima.

3.17 MEDICAL AND ADMINISTRATIVE RECORDS --- Physician shall require that all Participating Providers and Subcontractors establish and maintain for each Member who has obtained Covered Services from a Participating Provider or Subcontractor a legible Medical Record. Such Medical Record shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Participating Provider or Subcontractor. Such Medical Record shall be in such a form as to allow trained health professionals, other than the Participating Provider or Subcontractor, to readily determine the nature and extent of the Member's medical problem and the services provided and permit peer review of the services provided. The Medical Record shall be kept in a detail consistent with good medical and professional practice in accordance with 22 CCR Section 53284, and which permits effective professional review and facilitates a system of follow-up treatment. All Medical Records shall meet the requirements of the State Contract and applicable laws and regulations, including, but not limited to, 28 CCR Section 1300.80(b)(4) and 42 USC Section 1396a(w). Such records shall be available to health care providers at each encounter, in accordance with 28 CCR Section 1300.67.1(c). Physician shall ensure that an individual is delegated the responsibility of securing and maintaining Medical Records at each Participating Provider or Subcontractor site.

3.17.1 Physician and CalOptima agree to maintain the confidentiality of the Member's Medi-Cal status and information contained in the Member's Medical Records in accordance with federal and State law. Physician shall require that all Participating Providers and Subcontractors maintain the confidentiality of a Member's Medi-Cal status and information contained in a Member's Medical Records in accordance with federal and State Law.

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3.17.2 Medical records under this Section shall reflect all aspects of patient care, including ancillary services in accordance with CalOptima Policies.

3.17.3 It is understood that all Physician, Subcontractors', and Participating Providers' books and records pertaining to goods and services furnished under this Contract:

3.17.3.1 Shall be made available for inspection or copying at Physician, Participating Providers' and/or Subcontractors' expense by CalOptima or authorized representative of State or federal government at all reasonable times at the Physician, Participating Providers' or Subcontractors' place of business or at such other mutually agreeable location in California; and

3.17.3.2 Shall be maintained in accordance with the general standards applicable to such book or record keeping.

3.18 RECORDS RETENTION --- Physician and Subcontractors shall retain, preserve and make available upon request all records relating to the performance of its obligations under the Contract, including claim forms and encounter data, for a period of not less than ten (10) years from the final date of the contract between CalOptima and DHCS, or the date of completion of any audit, whichever is later, unless a longer period is required by law, with the exception in which the Physician or Subcontractor has been duly notified that DHCS, DHHS, the Department of Managed Health Care, the Department of Justice or Comptroller General of the United States, or their duly authorized representative have commenced an audit or investigation of the Contract or any Subcontract, until such time as the matter under audit or investigation has been resolved, whichever is later. Records involving matters that are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Pediatric records for un-emancipated minor Members shall be maintained until the latter of the full retention period under this Section, or at least one (1) year after the Member has reached eighteen (18) years of age. Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable and are supported by an effective retrieval system.

3.18.1 Physician shall upon request of CalOptima, transfer copies of such records to CalOptima's possession. No records shall be destroyed or otherwise disposed of prior to the retention period stated in Section 3.18 without the prior written consent of CalOptima. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

3.19 ACCESS TO PREMISES --- CalOptima and the State, through any authorized representatives, have the right at all reasonable times to monitor, inspect or otherwise evaluate the work performed or being performed hereunder, including subcontract supported activities and the premises in which it is being performed. If any monitoring, inspection or evaluation is made of the premises of Physician or Subcontractor, Physician shall provide, and shall require Subcontractors to provide, all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All monitoring, inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

3.19.1 Through the end of the records retention period specified in Section 3.18, Physician shall make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the State Contract, Exhibit E, Attachment 2, Provision 21: (a) by CalOptima and/or CalOptima's Regulators; (b) at all reasonable times at the Physician's place of

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business or such other mutually agreeable location in California; (c) in a form maintained in accordance with the general standards applicable to such book or record keeping; and (d) including all encounter data for a period of at least ten (10) years.

3.19.2 Through the end of the records retention period specified in 3.18, Physician shall allow CalOptima and/or CalOptima's Regulators to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, Facilities, contracts, computers, or other electronic systems maintained by Physician and Subcontractors pertaining to these services at any time,, pursuant to 42 CFR section 438.3(h). Records and documents include but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, Medical Records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Section 3.18, Physician shall furnish any record, or copy of it, to CalOptima, DHCS or any other CalOptima's Regulators, at Physician's sole expense. CalOptima and DHCS may conduct unannounced validation reviews of the Physician's Primary Care or other service sites, selected at DHCS' discretion, to verify compliance of these sites with State and Federal regulations and Contract requirements. CalOptima and authorized State and Federal agencies will have the right to monitor all aspects of Physician's operation for compliance with the provisions of this Contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Physician, Subcontractor, and provider facilities, management systems and procedures, and books and records as CalOptima or DHCS deems appropriate, at any time, pursuant to 42 CFR section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, CalOptima, the State and their authorized representatives and designees will have the right to premises access, with or without notice to Physician. This will include the MIS operations site or such other place where duties under the Contract are being performed. Staff designated by CalOptima and authorized State agencies will have access to all security areas and Physician will provide, and will require any and all of its Subcontractors to provide, reasonable facilities, cooperation and assistance to the CalOptima or State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Physician and/or the Subcontractor(s).

3.20 ACCESS TO AND AUDIT OF CONTRACT RECORDS. Throughout the duration of the Contract and the retention period specified in Section 3.18, Physician and Subcontractor shall provide duly authorized representatives of the State or federal government or CalOptima access to all records and material relating to Physician's provision of and reimbursement for activities contemplated under the Contract, and to Physician's financial condition and ability to bear risk under applicable state and federal laws. Such access shall include the right to inspect, audit and have available all such records and material and to verify reports furnished in compliance with the provisions of the Contract. All information so obtained shall be accorded confidential treatment as provided under applicable law. CalOptima employees shall sign Physician's statement of confidentiality prior to being admitted access to Physician's premises. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Physician at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Physician from participation in the Medi-Cal program; seek recovery of payments made to the Physician; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract due to fraud.

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3.21 RECORDS RELATED TO RECOVERY FOR LITIGATION --- Upon request by CalOptima, Physician shall timely gather, preserve and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Physician's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Physician asserts that any requested documents are covered by a privilege, Physician shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state the privilege being claimed that supports withholding production of the document. Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Physician acknowledges that time may be of the essence in responding to such request. Physician shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Physician or its Subcontractors related to this Contract or subcontracts entered into under this Contract.

3.21.1 Physician further agrees to timely gather, preserve, and provide to DHCS any records in the Physician's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation" Provision.

3.22 MEMBER REQUEST FOR MEDICAL RECORDS --- Physician and Subcontractor shall furnish a copy of a Member's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider or an Out of Network Provider, at no cost to CalOptima or to the Member when:

3.22.1 Such a transfer of records facilitates the continuity of that Member's care; or

3.22.2 The Member is transferring from one Provider to another for treatment; or

3.22.3 A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

3.23 DISCLOSURE OF OWNERSHIP -- Physician shall fully and accurately complete the disclosure form in Attachment B and submit the disclosure form to CalOptima prior to the Effective Date. Physician shall promptly notify CalOptima of any changes to the information contained in the disclosure form in Attachment B and submit an updated disclosure form to CalOptima within thirty (30) days of any such change.

3.23.1 If Physician is of a provider type that is not eligible to be Medi-Cal enrolled through DHCS, Physician shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations, for its providers.

3.24 FRAUD AND ABUSE REPORTING --- Physician shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Participating Providers, Out-of-Network Providers, Members, or Physician's employees, within five (5) working days of the date when Physician first becomes aware of or is on notice of such activity.

3.24.1 Physician shall notify CalOptima, and CalOptima shall notify DHCS prior to Physician conducting any investigations. Physician shall conduct an investigation after notification has been given.

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3.24.2 Physician shall provide to CalOptima and/or CalOptima's Regulators, upon request, written policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program.

3.24.3 Physician shall report all investigation results to CalOptima within two (2) working days of conclusion of any fraud and/or abuse investigation.

3.25 COMPLIANCE WITH APPLICABLE LAW --- Physician shall observe and comply with all federal and State law in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects the Physician's performance under this Contract. This Contract shall be governed by and construed in accordance with applicable federal and State law and with the terms and obligations under the State Contract.

3.26 PHYSICIAN COMPLIANCE PROGRAM --- Physician shall develop and implement a comprehensive and effective Compliance Program, including a Compliance Plan. Such Compliance Program shall include, but is not limited to, the implementation of the Office of Inspector General's (OIG) 7 Elements of an Effective Compliance Program: Standards & Procedures, Oversight, Education & Training, Auditing & Monitoring, Reporting, Enforcement and Discipline, and Response & Prevention. Compliance Programs shall be evaluated by the Physician annually to ensure that it remains effective. Physician shall make the Plan and related documents available to CalOptima upon request.

3.27 COMPLIANCE WITH CALOPTIMA'S COMPLIANCE PROGRAM ---Physician and its employees, board members, owners, Participating Providers and/or Subcontractors furnishing medical and/or administrative services under this Contract ("Physician's Agents") shall comply with the requirements of CalOptima's Compliance Program, as may be amended from time to time, including the Code of Conduct and Compliance Plan. CalOptima shall make its Compliance Manual and Code of Conduct available to Physician and Physician shall make them available to Physician's Agents.

3.28 COMPLIANCE WITH STATE AND FEDERAL PROGRAMS --- Physician shall comply with requirements established by State and/or federal programs relating to its performance under this Contract. Physician's compliance shall include, but not be limited to, applicable requirements of the DHCS Medi-Cal Managed Care Program, provisions of the State Contract requirements for CalOptima to maintain CMS waiver, Operational Instruction Letters (OILs), Medi-Cal Managed Care Division Policy Letters and All Plan Letters, as well as applicable requirements specified in the State Contract and subsequent amendments, and State and federal laws and regulations.

3.29 COMPLIANCE WITH POLICIES AND PROCEDURES --- Physician agrees to comply with and be bound by CalOptima Policies. CalOptima reserves the right to adopt, amend and/or discontinue CalOptima Policies at its sole discretion. Physician acknowledges and agrees that it shall implement CalOptima Policies applicable to its obligations under this Contract.

3.30 COMPLIANCE WITH MEMORANDUM/MEMORANDA OF UNDERSTANDING (MOUs) --- Physician agrees to comply with and be bound by any and all applicable MOUs entered into by CalOptima. Physician agrees to require Subcontractors to comply with applicable requirements of such MOUs.

3.31 COMPLIANCE WITH PARTICIPATION STATUS REQUIREMENTS --- Physician shall have policies and procedures to verify the Participation Status of Physician's Agents. Physician shall refer to the Department of Health and Human Services, Office of Inspector General List of Excluded Individuals and Entities (LEIE) (http://oig.hhs.gov), as well as the GSA Excluded Parties Lists Systems (EPLS) in the SAM System (https://www.sam.gov). In addition, Physician warrants and agrees as follows:

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3.31.1 Physician and Physician's Agents shall meet CalOptima's Participation Status requirements during the term of this Contract.

3.31.2 Physician shall immediately disclose to CalOptima any pending investigation involving, or any determination of, suspension, exclusion or debarment by Physician or Physician's Agents occurring and/or discovered during the term of this Contract.

3.31.3 Physician shall take immediate action to remove any Physician Agent that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to Members and shall immediately notify CalOptima.

3.31.4 Physician shall include the obligations of this Section in its Subcontracts.

3.31.5 CalOptima and Physician, as applicable, shall not make payment for a health care item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Physician shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

3.32 NON-DISCRIMINATION --- During the performance of this Contract, neither Physician nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. Physician and Subcontractors shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Physician and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, et seq.) and the applicable regulations promulgated thereunder (CCR, Title 2, Section 7285.0, et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Physician and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Physician shall include the non-discrimination and compliance provisions of this Section in all Subcontracts to perform work under this Contract.

3.32.1 Physician and all Subcontractors shall abide by Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the Physician nor Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons of groups defined in Penal Code 422.56 in accordance with Title VI of the Civil Rights Act of 1964, 42 USC, Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act;

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and all rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

3.32.2 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service which is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating a Member differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions which individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

3.32.3 Physician shall take affirmative action to ensure that all Members are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

3.32.4 Physician shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Member Complaint Policy and shall forward copies of all such grievances to CalOptima, attention Grievance & Appeals Resolution Services, within five (5) days of receipt of same.

3.32.5 Physician shall require all downstream providers to cooperate with CalOptima's Member Complaint Policy and time requirements to appeals within designated time frames.

3.33 LINGUISTIC AND CULTURAL SENSITIVITY --- CalOptima will provide cultural competency, sensitivity, and diversity training. Physician shall comply with all the following requirements related to the provision of linguistic and culturally sensitive services in accordance with this Contract and CalOptima Policies.

3.33.1 Physician shall have a Cultural and Linguistic Services Program that monitors, evaluates, and takes effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Physician shall provide cultural competency, sensitivity, or diversity training for staff, providers and Subcontractors at key points of contact. Physician shall provide orientation and training on cultural competency to staff and providers serving Members. The training objectives shall include teaching participants an enhanced awareness of cultural competency imperatives and issues related to improving access and quality of care for Members, as well as information on access to interpreters, and how to work with interpreters. Physician shall also, as appropriate, refer Members to culturally-appropriate community services programs.

3.33.2 Pursuant to CalOptima Policies, Physician shall provide translation of written member informing materials in the Threshold and Concentration Languages. Physician shall comply with the language assistance standards developed pursuant to California Health and Safety Code section 1367.04. Written member informing materials to be translated include, but are not limited to: 1) signage; 2) Evidence of Coverage and/or Member Services Guide; 3) disclosure forms; 4) provider listing or directories; 5) marketing materials; 6) form letters; 7) plan-generated preventive health reminders; 8) member

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surveys; and 9) newsletters. If a Member requests materials in a language not meeting the numeric Thresholds or Concentration Standards, Physician shall provide oral translation of the written materials utilizing bilingual staff or a telephonic interpreter service. Physician shall also make materials available to Members in alternate formats (e.g. Braille, audio, large print) upon request of the Member. Physician shall be responsible for ensuring the quality of translated materials at no cost to CalOptima or Member.

3.34 PROVISION OF INTERPRETERS --- Physician shall, at no cost to Members, provide linguistic interpreter services and interpreter services for the deaf or hard of hearing for all Members at all key points of contact, including telephone, advice and urgent care transactions, and outpatient encounters, and all sites utilized by Physician or any Subcontractors, as well as member services, orientations, appointment setting and similar administrative functions, as necessary, to ensure the availability of effective communication regarding treatment, diagnosis, medical history or health education. Physician shall have in place telephonic and face-to-face interpreter services and American Sign Language interpreter services contracts. Physician shall provide twenty-four (24) hour access to interpreter services for all Members, and shall implement policies and procedures to ensure compliance by subcontracted providers with these standards. Such access shall include access for users of Telecommunication Devices for the Deaf (TDD) or Telecommunications Relay Services (711 system). Upon a Member or Participating Provider request for interpreter services in a specific situation where care is needed, Physician shall make all reasonable efforts to provide a face-to-face interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services. If face-to-face interpretation is not feasible, Physician must ensure provision of telephonic interpreter services or interpretation through bilingual staff members. Physician shall routinely document the language needs of Members and the request or refusal of interpreter services in a Member's medical record. This documentation shall be available to CalOptima at CalOptima's request. Physician shall not require or suggest that a Member to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Member; (ii) will not compromise the effectiveness of service; (iii) will not violate Member's confidentiality; and (iv) the Member is advised that an interpreter is available at no cost to the Member. Physician shall ensure the linguistic capabilities and proficiency of individuals providing interpreter services.

3.35 MEMBER RIGHTS --- Physician shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policy, are fully respected and observed. Physician shall make Member Rights available to Member.

3.36 PARTICIPATING PROVIDER-MEMBER COMMUNICATION --- Physician shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice from communicating with Members, and shall encourage its health care professionals to freely communicate the following to patients, regardless of benefit coverage:

3.36.1 The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

3.36.2 Any information the Member needs in order to decide among all relevant treatment options.

3.36.3 The risks, benefits, and consequences of treatment or non-treatment.

3.36.4 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.37 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE

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3.37.1 Physician and CalOptima shall make any and all efforts and take any and all actions necessary to comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements, but not later than the time permitted by the applicable HIPAA requirement after date of finalization.

3.37.2 Physician shall comply with HIPAA requirements as currently established in CalOptima Policies. Physician shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

3.37.3 The parties agree to comply with the terms and conditions of the Physician HIPAA Business Associates Agreement.

3.38 CONFIDENTIALITY OF INFORMATION

3.38.1 Physician and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Contract or persons whose names or identifying information become available or are disclosed to Physician, its employees, agents, or Subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. Physician and its employees, agents, or Subcontractors shall not use such identifying information for any purpose other than carrying out Physician's obligations under this Contract. Physician and its employees, agents, or Subcontractors shall promptly transmit to the CalOptima all requests for disclosure of such identifying information not emanating from the Member. Physician shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include Protected Health Information (PHI): names, geographical subdivisions smaller than a state, all elements of dates (except for year), phone and fax numbers, e-mail address, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, license numbers, vehicle identifiers, device identifiers, web Universal Resource Locators (URLs), internet protocol address numbers, biometric identifiers, including finger and voice prints, full face photograph images, any other unique identifying number, characteristic or code.

3.38.2 Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by Physician from unauthorized disclosure. Physician may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Physician is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by Physician or its Subcontractors, Physician:

3.38.2.1 will not use any such information for any purpose other than carrying out the express terms of this Contract,

3.38.2.2 will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law,

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3.38.2.3 will not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under, and

3.38.2.4 will, at the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to the Physician by DHCS for this purpose.

3.39 REINSURANCE -- CalOptima arranges for the provision of reinsurance, as described more fully in CalOptima Policies. CCS Eligible Members with CCS Eligible Conditions shall be excluded from CalOptima's provision of reinsurance. Physician may, at its option and sole expense purchase supplemental Reinsurance from a source other than CalOptima. Additionally, Physician shall:

3.39.1 Identify a Reinsurance coordinator who shall serve as CalOptima's contact for all Reinsurance issues; and

3.39.2 Comply with CalOptima Policies for monitoring and monthly reporting of all Reinsurance claims activities.

3.39.3 In lieu of CalOptima-provided reinsurance, services for CCS Members shall be subject to interim reimbursement for catastrophic cases and retrospective risk corridors, as provided in Attachment E of this Contract.

3.40 CLAIMS MANAGEMENT AND ADMINISTRATION --- Physician shall have a process for claims management and administration. Physician shall maintain a claim retrieval system that can, on request, identify the date of receipt, the action taken on all Provider claims (i.e., paid, denied, pended, other), and when action was taken. Physician shall date stamp all Provider claims upon receipt. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

3.41 TWENTY-FOUR (24) HOUR TELEPHONE COVERAGE --- Physician shall have one (1) California State wide toll-free telephone number listed on the Automated Eligibility Verification System (AEVS) that Providers, Members or individuals acting on behalf of Members can call at anytime (twenty-four (24) hours/seven (7) days a week) to obtain authorization for all CalOptima Covered Services. Twenty-four (24) hour telephone coverage shall be made available in all Threshold Languages. The number shall connect the Member or Member's representative or Provider to an individual who shall either:

3.41.1 Have authority to approve Covered Services; or

3.41.2 Have the ability to transfer the Member or Member's representative to an individual with authority without disconnecting the call; and

3.41.3 In case of emergency, direct the Member or Member's representative to hang up and dial 911 or go to the nearest emergency room; and

3.41.4 Respond to Provider or Member's call within thirty (30) minutes. Failure to respond to such call within thirty (30) minutes shall result in the Physician being liable for the cost of subsequent Medically Necessary Covered Services related to that illness or injury whether or not that treatment has been authorized; and

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3.41.5 Have the capability to coordinate continuous care and follow-up Covered Services, including referrals to Specialist Physicians, for all Members who have received a MSE or Emergency Services and have been Stabilized.

3.41.6 All calls shall be logged in with time, date and any pertinent information related to persons involved, resolution and follow-up instructions. Physician shall notify CalOptima if the toll free telephone number changes no less than seven (7) working days prior to the change.

3.42 OBLIGATIONS UNDER PRIOR CONTRACT --- Physician acknowledges and agrees that certain of its obligations and duties under the Prior Contract, if previously contracted, survive the expiration of the Prior Contract and/or are measured following the expiration of the Prior Contract (including, without limitation, corrective action plans, quality improvement and credentialing functions, financial requirements). Physician shall perform all such obligations and duties. For purposes of this section, "Prior Contract" means the contract for health care services previously entered into between Physician and CalOptima pursuant to which Physician agreed to provide or arrange for the provision of Medi-Cal Covered Services to Members.

3.43 EMPLOYEE EDUCATION ON FALSE CLAIMS ACT --- Physician shall comply with the requirements contained in 42 USC § 1396a(a)(68)(A)-(C) as a condition of receiving payment under this contract. Physician shall, upon request of CalOptima, demonstrate compliance with this provision, including providing CalOptima with copies of Physician's applicable written policies and procedures, any relevant employee handbook excerpts, and other educational materials used to meet this requirement.

3.44 MONITORING --- Physician shall comply with all monitoring provisions of this Contract and the State Contract, and any monitoring requests by CalOptima and DHCS.

3.45 PHYSICIAN SUBCONTRACTS --- In addition to Section 3.9 of this Contract, Physician shall maintain and make available to CalOptima, DHCS, or other CalOptima's Regulators, upon their respective requests, copies of all Subcontracts. Physician shall ensure that all Subcontracts are in writing and require that the Physician and its Subcontractors:

3.45.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima and/or CalOptima's Regulators, or their designees.

3.45.2 Retain such books and all records and document for a term minimum of at least ten (10) years from the final date of the State Contract period or from the final date of completion of any audit, whichever is later.

3.46 CALOPTIMA OVERSIGHT – Physician understands and agrees that CalOptima is responsible for the monitoring and oversight of all obligations of Physician under this Contract. In instances where DHCS or CalOptima determines that the Physician or any of the Subcontractors has not performed satisfactorily, CalOptima shall have the right to (a) amend or revoke the delegation of activities or obligations to the Physician, (b) require the Physician to amend or revoke the sub-delegation of activities or obligations to the Subcontractors, and/or (c) specify other remedies, including, but not limited to, those set forth in Sections 13.1 through 13.1.3.2. Physician shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with applicable laws and regulations, accreditation organization standards, and/or CalOptima Policies governing the obligations of Physician or the oversight of those obligations.

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3.47 Information and Cyber Security. Physician must have policies, procedures, and practices that address its information and cyber security measures, safeguards, and standards, including at least the following:

3.47.1 Access Controls. Access controls, including Multi-Factor Authentication, to limit access to Physician's information systems and any CalOptima information that Physician maintains or can access.

3.47.2 Encryption. Use of encryption to protect any CalOptima information, in transit and at rest, that Physician maintains or can access.

3.47.3 Security. Safeguards for the security of the information systems and CalOptima information that Physician maintains or can access, including hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, physical security controls, and personnel training programs that include phishing recognition and proper data management hygiene.

3.47.4 Software Maintenance. Software maintenance, support, updates, upgrades, third-party software components and bug fixes such that the software is, and remains, secure from vulnerabilities in accordance with the applicable industry standards.

3.47.5 Network Security. Network security that conforms to generally recognized industry standards and best practices.

For the purpose of this Section 3.47, "**Multi-Factor Authentication**" means authentication through verification of at least two (2) of the following types of authentication factors: (i) knowledge factors, such as a password; (ii) possession factors, such as a token or text message on a mobile phone; (iii) inherence factors, such as a biometric characteristic; or (iv) any other industry standard and commercially accepted authentication factors.

ARTICLE 4
Obligations of Physician – Provision of Covered Services

4.1 PROVISION OF COVERED SERVICES TO MEMBERS --- Physician shall provide Covered Services to Members under this Contract in the same manner as those services are provided to other patients of Physician, but in no case less than the amount of such services provided under the Medi-Cal Fee-for-Service Program. Consistent with the concept that Physician is the medical home of the Member, where the Member receives the majority of the Member's care and where the Member's overall health status, need for care and services, and wellness are assessed, evaluated, monitored, managed, enhanced and/or maintained, Physician shall coordinate Members' needs for Covered Services and provide Care Management Services and other services to assure Members receive all necessary care and services without regard to the party financially responsible for care and services. Physician shall provide Covered Services to Members and Physician agrees as follows:

4.1.1 Physician shall provide and pay for, consistent with the terms and provision of this Contract and CalOptima Policies, the provision of all Covered Services to Members that are the financial responsibility of Physician as set forth in Attachment A, with the exception of certain Medical Supplies identified in Attachment C;

4.1.2 If Physician's network is unable to provide necessary medical services covered under this Contract to a particular Member, Physician must adequately and timely cover these services

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out of network for the Member, for as long as Physician is unable to provide them. Physician shall make prior arrangements with Out-of-Network Providers for the provision of such services, and shall be fully responsible for arranging and paying for such services, and shall comply with all applicable CalOptima Policies with regard to the payment and authorization of Out-of-Network Providers;

4.1.3 Physician shall be liable for the provision of and payment for all Covered Services notwithstanding a delay in payment of the Capitation Payment;

4.1.4 CalOptima may incorporate any change in Covered Services mandated by federal or State law or regulation into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the Physician thirty (30) calendar days' notice of any such change. CalOptima shall determine the effective date of the change in Covered Services;

4.1.5 The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians participating with Physician as to the Medical Necessity of the service, except that each Physician shall provide assessment and evaluation services ordered by a court or legal mandate;

4.1.6 Physician shall comply with Jackson v. Rank, U.S. District Court (E.D. Cal.), No. CIV 5-83-1451 LKK, June 9, 1986, and notify its Members when the Physician denies, modifies or defers a PCP's request for authorization or terminates a previously authorized service;

4.1.7 Decisions concerning whether to provide or authorize Covered Services shall be based solely on Medical Necessity. Physician acknowledges that disputes between the respective Physician and Members about Medical Necessity can be appealed pursuant to CalOptima Policies;

4.1.8 Physician may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Physician may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose; and

4.1.9 Physician shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay capitation payments pursuant to this Contract. In no event, including but not limited to, non-payment by CalOptima or Physician, CalOptima's or the Physician's insolvency, or breach of this Contract by the Physician or CalOptima, shall Physician or Subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State, a Member or persons acting on the behalf of a Member for Covered Services provided pursuant to this Contract. This provision does not prohibit Physician or Subcontractors from collecting co-payments and deductibles, if any, as specifically provided for in this Contract or for recoveries related to other health coverage, as identified in Section 2.8 of this Contract. Physician or a Subcontractor may bill a Member and collect fees for non-Covered Services from the Member if the Member agrees to the fees in writing prior to the actual delivery of non-Covered Services, and a copy of such agreement is given to the Member and placed in the Member's Medical Record. Physician further agrees:

4.1.9.1 That this Section shall survive the termination of this Contract for those Covered Services rendered prior to the termination of this Contract, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members;

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4.1.9.2 That this Section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Physician and Participating Providers or Subcontractors;

4.1.9.3 That language to ensure the foregoing shall be included in all of the Physician's Subcontracts with Participating Providers;

4.1.9.4 That no change or amendment to this Section or to similar section(s) in Subcontracts between the Physician and Participating Providers shall be made without the prior written approval of CalOptima; and

4.1.9.5 That, in the event of a violation of this Section by Physician or Subcontractor, including, but not limited to, balance billing of Member for Covered Services provided under the Contract or Subcontract, CalOptima shall take appropriate remedial action against Physician or Subcontractor, including, but not limited to, repayment of any amounts collected, and appropriate Sanctions, as provided for in Section 13.1.

4.1.10 Physician shall refer CalOptima Members to providers that have hospital privileges at CalOptima contracted facilities, whenever possible.

4.2 EMERGENCY CARE --- Physician shall comply with all applicable State and federal laws and regulations governing the provision and payment of Emergency Services, as well as the applicable requirements of the State Contract (including, but not limited to, Exhibit A, Attachment 8, Provision 12). Physician is required to provide and pay for all Emergency Services, including Emergency Services provided by Out-of-Network Providers, without prior authorization, twenty-four (24) hours each day, seven (7) days a week.

4.2.1 Physician shall reimburse or authorize reimbursement, as appropriate, for all Emergency Services without prior authorization, and in accordance with CalOptima Policy. Payment may be denied only if Physician reasonably determines that Emergency Services were never performed.

4.2.2 Not Applicable to this Contract.

4.2.3 Physician shall reimburse those physicians providing services in an Emergency Department with whom Physician has a contract according to the terms of that contract. Physician shall offer to enter into a contract with any physician group contracting with CalOptima for the provision of physician services in an Emergency Department on the same terms, conditions and rates as provided for in that CalOptima contract. Physician shall reimburse all other non-contracted physicians providing services in an Emergency Department in accordance with the Deficit Reduction Act of 2005, 42 USC 1396u-2(b)(2)(D), and CalOptima Policy.

4.2.4 Physician shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition as defined in Section 1.34, turned out to be non-emergency in nature.

4.2.5 An Emergency Medical Condition shall not be limited based on a list of diagnoses or symptoms. Physician shall not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have resulted in an outcome specified in Section 1.34. Further, Physician shall not deny payment for treatment obtained when Physician or a Participating Provider instructs the Member to seek Emergency Services.

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4.2.6 Physician shall reimburse the County of Orange for Emergency Services and Urgent Care Services provided to Members at Orangewood Children's Home or while in Foster Care during periods of emergency foster placement or court-ordered stays. Payment shall be based on the prevailing Medi-Cal Fee Schedule.

4.2.7 If there is a disagreement between Physician or any Participating Provider and Out of Network Provider regarding Medically Necessary Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Member at the treating facility shall prevail. Physician may establish relationships with treating facility whereby the Physician may send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment or may arrange to have a Participating Provider under contract with Physician agree to accept the transfer of the Member after the Member has been Stabilized. The attending emergency physician, or the Provider actually treating the Member is responsible for determining when the Member is sufficiently Stabilized for transfer or discharge and that determination is binding on Physician.

4.2.8 Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). Physician is financially responsible for post-stabilization services obtained within or outside Physician's network that are pre-approved by a plan provider or other entity representative. Physician is financially responsible for post-stabilization care services obtained within or outside Physician's network that are not pre-approved by a plan provider or other Physician representative, but administered to maintain the Member's Stabilized condition within 1 hour of a request to Physician for pre-approval of further post-stabilization care services.

4.2.8.1 Physician is also financially responsible for post-stabilization care services obtained within or outside Physician's network that are not pre-approved by a plan provider or other entity representative, but administered to maintain, improve or resolve the Member's Stabilized condition if Physician does not respond to a request for pre-approval within 30 minutes; Physician cannot be contacted; or Physician's representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, Physician must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria of 422.133(c)(3) is met.

4.2.8.2 Physician's financial responsibility for post-stabilization care services it has not pre-approved ends when a plan physician with privileges at the treating hospital assumes responsibility for the Member's care, a plan physician assumes responsibility for the Member's care through transfer, a plan representative and the treating physician reach an agreement concerning the Member's care; or the Member is discharged.

4.2.8.3 Not Applicable to this Contract.

4.2.8.4 Consistent with 42 CFR 438.114(e), 422.1 13(c)(2), and 422.214, Physician is financially responsible for payment for post-stabilization services following an emergency admission. Physician shall reimburse those physicians providing post-stabilization services with whom Physician has a contract according to the terms of that contract. Physician shall reimburse all non-contracted physicians providing post-stabilization services in accordance with the Medi-Cal Fee Schedule as defined in CalOptima Policy.

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4.3 NEWBORN SERVICES --- Physician shall provide all Covered Services to any newborn child born to a Member for the month of the birth and the following month.

4.4 FAMILY PLANNING --- Physician is solely responsible for developing policies and procedures to ensure that Member's Family Planning information and records are confidential as required by State law. Family Planning information and records shall not be released to any third party without the consent of the Member. Notwithstanding the foregoing, Physician shall provide Family Planning information to CalOptima, or authorized representatives of the State or federal government or the Member's PCP to maintain consistency of the Member's Medical Record. Physician's Subcontracts with PCPs must include language regarding the confidentiality of Family Planning documents, information and records. Prior authorization for Family Planning services, shall not be required.

4.4.1 Physician shall comply with OBRA 1987, Section 4113(c)(1)(B), which requires Physician to certify that it shall not restrict or prevent a Member from selecting a Participating Provider or an Out of Network Provider to deliver Family Planning Covered Services and supplies. This does not relieve Physician from financial responsibility for such services.

4.4.2 Physician shall not prevent Members from receiving Family Planning Covered Services from Out of Network Providers.

4.4.3 Physician shall provide information that clearly explains the rights of the Member regarding the choice of Family Planning Providers. Physician shall also provide similar information to all Providers who are either PCPs, obstetricians, gynecologists, or urologists. The intent of this information is to implement the specifications of this paragraph by arranging for the availability of consistent and accurate information from the Member's PCP, obstetrician, gynecologist, or urologist about the Member's rights to freedom of choice regarding Family Planning Providers.

4.4.4 Physician shall provide information to Members and Participating Providers about a Member's right to file a grievance or request a State hearing, in accordance with CalOptima Policies, for any reason including if the Member has reason to believe that the Physician has restricted, prevented, impaired or denied the Member's free choice of Family Planning Providers.

4.4.5 Physician shall incorporate specifications of this Section in its Subcontracts with its PCPs, obstetricians, gynecologists, and urologists.

4.5 ANCILLARY SERVICES FOR LONG TERM CARE --- Physician shall provide authorized Covered Services, including ancillary Covered Services for both emergent and routine laboratory tests and x-rays, not included in the facility day rate for all Members residing in Long Term Care Facilities.

4.6 ACCESS TO SERVICES TO WHICH PHYSICIAN OR A SUBCONTRACTOR HAS A MORAL OBJECTION --- Unless prohibited by law, Physician shall not be required to directly perform the provision of Covered Services for which Physician and/or Subcontractor has a religious or ethical objection to perform or otherwise support per section 14.20 Catholic Directives of this agreement. Physician shall not hinder nor restrict a Member from obtaining Covered Services.

4.7 ALCOHOL MISUSE SCREENING AND COUNSELING -- Physician shall ensure the provision of AMSC services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond AMSC. Physician shall document AMSC services in Members Medical Records.

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4.8 AMERICAN INDIAN HEALTH SERVICE PROGRAMS --- American Indian Health Service Programs can operate as a Primary Care Physician for American Indian Members, and as such can provide referrals directly to network Physician without first requesting a referral from a network Primary Care Physician. Physician shall ensure timely access to American Indian Health Service Programs by including American Indian Health Service Programs within Physician's network for American Indian Members in accordance with 42 CFR 438.14(b).

4.9 PARTICIPATION IN CALOPTIMA WHOLE CHILD MODEL PROGRAM --- Physician acknowledges and agrees that its participation in CalOptima WCM is conditioned on transfer of CCS to CalOptima and meeting DHCS access and other requirements. Upon meeting those conditions, CalOptima shall notify Physician of the date upon which Physician will be considered to be "Participating in the CalOptima Whole Child Model Program" as this phrase is used in this Contract, and at which time Physician shall commence all CalOptima WCM obligations.

ARTICLE 5
Obligations of Physician – Access

5.1 TWENTY-FOUR (24) HOUR PHYSICIAN COVERAGE ---- Physician shall ensure that a physician Participating Provider or physician employed by Physician is available twenty-four (24) hours a day, seven (7) days a week for timely authorization and consultation for Medically Necessary Covered Services, including, but not limited to, authorizing Medically Necessary post-stabilization care, coordinating the transfer of Stabilized Members in an emergency department, and for general communication with emergency room personnel, if necessary, in accordance with CalOptima Policies. In addition, Physician shall ensure disputed requests for authorizations are timely resolved in accordance with applicable law and regulations, as well as CalOptima Policies

5.2 URGENT CARE SERVICES --- Physician shall make Covered Services available within twenty-four (24) hours or as appropriate for Urgent Care.

5.3 INITIAL HEALTH ASSESSMENT APPOINTMENT --- Physician shall have a process in place to ensure each Member is scheduled for an initial health assessment within one hundred twenty (120) calendar days following enrollment with CalOptima, unless otherwise directed by CalOptima Policies. At a minimum, an initial health assessment shall include administration of the Staying Healthy Assessment Tool, a medical history, weight and height data, blood pressure, preventive health screens and tests which are required under CalOptima Policies, discussion of appropriate preventive measures, and arrangement of future follow-up appointments as indicated. The initial health assessment shall include the identification, assessment and development of care plans as appropriate for Members with special health care needs. The initial and periodic health assessment appointments shall include a dental screening/oral health assessment for all Members under 21 years of age and include annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first. Physician shall ensure that Members are referred to appropriate Medi-Cal dental Providers and provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish. CalOptima may establish minimum performance requirements for completion of the initial health assessment. Physician's failure to perform at or in excess of minimum performance requirements shall subject Physician to sanctions in accordance with this Contract and CalOptima Policies. Physician shall ensure that health assessment information shall be recorded in the Member's Medical Record.

5.4 APPOINTMENT FOR PEDIATRIC PREVENTIVE COVERED SERVICES --- Physician shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics (AAP) periodic schedule and/or DHCS requirements. Immunizations are to be provided according to the latest guidelines published by the AAP and the Advisory Committee on Immunization Practices (ACIP). If there are any conflicts in the recommendations, the higher standard shall be recognized. Adults shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force.

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5.5 Not Applicable to this Contract.

5.6 DAYS TO APPOINTMENT---

5.6.1 Non-Emergency Covered Services – Physician shall ensure that appointments are scheduled with a PCP for non-emergency or non-urgent Covered Services within ten (10) business days of a Member's request. Physician shall also have a process in place for follow-up on Member missed appointments.

5.6.2 Specialist Services – Physician shall ensure that appointments are scheduled with Specialists within fifteen (15) business days of request of appointment. Physician shall arrange for the provision of specialty services from specialists outside the network if unavailable within Physician's network, when determined medically necessary.

5.6.3 Preventive Covered Services – Physician shall schedule health assessments and general physical examinations in advance consistent with professionally recognized standards of practice as determined by the treating Provider acting within the scope of his or her practice and in accordance with CalOptima Policies.

5.6.4 Maternity Covered Services – Physician shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request. Subsequent routine appointments shall be scheduled in advance in accordance with applicable Department of Managed Health Care regulations governing timely access to non-emergency health care services. Physician shall cover and ensure the provision of all Medically Necessary services for pregnant Members. Physician shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services.

5.6.5 Measurement – Physician shall periodically measure days to appointment.

5.6.6 The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with Professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member.

5.6.7 Members shall be offered appointments within the following timeframes:

5.6.7.1 Urgent care appointment for services that do not require prior authorization – within 48 hours of a request;

5.6.7.2 Urgent appointment for services that do require prior authorization – within 96 hours of a request;

5.6.7.3 Non-urgent primary care appointments – within ten (10) business days of a request;

5.6.7.4 Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within 15 business days of request.

5.6.8 In the event that a Provider, including a PCP, is terminated or leaves the Physician for any reason, Physician shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS in accordance with applicable CalOptima Policies and regulatory requirements.

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5.7 OFFICE WAITING TIMES --- Physician shall periodically measure office waiting times to ensure compliance with CalOptima Policies, by its subcontracted Participating Providers, and shall take appropriate action to provide notice to Participating Providers if they are not meeting the wait time requirements that they may be sanctioned for such non-compliance up to and including termination of their Subcontract. Physician's failure to monitor and enforce Participating Provider office wait time requirements in accordance with the terms of this Contract may subject Physician to sanctions as set forth in this Contract and CalOptima Policies.

5.8 TIME LIMIT FOR DECISION ON REFERRALS --- Physician shall provide a decision on authorization requests for those Covered Services that are not Urgent Care Services or Emergency Services, including Specialty Physician referrals as set forth in CalOptima's utilization management program. These Covered Services shall be provided or made available to the Member within fifteen (15) calendar days after authorization is granted. Physician shall take no punitive action of any kind, and shall ensure that no Subcontractor takes any punitive action of any kind, against a Participating Provider or Subcontractor who either requests an expedited review or supports a Member's appeal.

5.9 CHANGES IN AVAILABILITY OR LOCATION OF COVERED SERVICES --- Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Physician's or a Subcontractor's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes. Physician's proposal shall allow for timely notice to Members to allow them to change PCPs if desired, as provided in Section 5.10 of this Contract.

5.10 NOTICES ABOUT PCP CHANGES --- Physician shall give Members thirty (30) calendar days' notice if their PCP withdraws from Physician. All notices sent to Members shall be submitted to CalOptima for prior approval before distribution to Members. Such notices must include instructions for selecting a new PCP should the Member not be satisfied with a new PCP assigned by Physician. With the exception of PCP terminations in which a provider is immediately terminated due to endangering the health and safety of patients, committing criminal or fraudulent acts or engaging in grossly unprofessional conduct, Members not receiving thirty (30) calendar days advance notice of PCP withdrawal shall be permitted to self-refer within the Physician for up to sixty (60) calendar days or until a new PCP is chosen by Member.

5.11 CHOICE OF PCP --- Physician shall offer each Member the opportunity to choose a PCP affiliated with the Physician. A Member may elect to obtain primary care services from a contracted non-physician medical practitioner as long as there is a physician who has ultimate responsibility for the Member's Care Management Services. When Physician receives the Member's files from CalOptima and determines that the Member has not indicated a PCP choice, Physician shall assign the Member to a PCP and include information about this assignment with the required enrollment information sent to the Member within seven (7) calendar days of notification of a Member's enrollment with Physician. Physician shall permit Members to change PCPs at least monthly, and to change more often if assignment of a specific PCP would be harmful to the interest of the Member.

5.12 PROVIDERS ELIGIBLE FOR PARTICIPATION IN MEDI-CAL --- Except in emergency situations, Physician shall use only Providers who are eligible for participation in the Medicare and/or Medi-Cal program to provide the Covered Services required under this Contract. Providers shall: (i) not be suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs; (ii) have not ever been suspended, excluded or otherwise ineligible to participate in any Federal and/or State health care programs based on a mandatory exclusion as defined in 42 U.S.C. § 1396a-7(a); and (iii) have not been convicted of any felony, or any misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with

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the interference with or obstruction of any investigation into health care related fraud or abuse or that has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program, within the previous 10 years.

5.13 PROVIDER TO MEMBER STAFFING RATIOS ---

5.13.1 Provider to Member Ratios - As specified by the State, Physician shall ensure that PCP staffing ratios satisfy the following full-time equivalent provider to Member ratios:

5.13.1.1 Primary Care Physicians 1:2,000 Members;
5.13.1.2 Total physicians 1:1,200 Members; and
5.13.1.3 If Non-Physician Medical Practitioners are included in Physician's Network, each individual Non-Physician Medical Practitioner shall not exceed a full-time equivalent provider/Member caseload of one (1) provider per 1,000 Members.

5.13.2 Supervising Physicians - Physician shall ensure that physicians who supervise non-physician mid-level staff are certified to supervise by the California Medical Board. As specified by the State, the ratio of physician supervisor to non-physician medical practitioner shall satisfy the requirement of a minimum of one (1) physician to:

5.13.2.1 Four (4) nurse practitioners; or
5.13.2.2 Four (4) physician assistants; or
5.13.2.3 Four (4) non-physician medical practitioners in any combination that does not include more than three (3) certified nurse midwives or two (2) physician assistants.

5.14 PCP GEOGRAPHIC DISTRIBUTION --- Physician shall maintain a network of PCPs, to make available to every Member a PCP whose office is located within thirty (30) minutes or ten (10) miles of Member's place of residence. Nothing in this provision shall be interpreted as preventing a Member from choosing a PCP beyond these geographic limits.

5.15 SPECIALIST GEOGRAPHIC DISTRIBUTION --- Physician shall make available to every Member, Specialists whose offices are located within fifteen (15) miles and thirty (30) minutes from the Member's place of residence as required in W & I Code Sections 14197(b) and (c). Physician shall provide transportation for Members when the nearest available Specialist is more than fifteen (15) miles or thirty (30) minutes from Member's place of residence.

5.16 PHYSICAL ACCESS --- Physician's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

5.17 ACCURACY OF PROVIDER DIRECTORY --- Physician shall notify CalOptima within five (5) business days when either of the following occur:

5.17.1 The Provider is not accepting new Members.

5.17.2 If the Provider had previously not accepted new Members, the Provider is currently accepting new Members

ARTICLE 6
Obligations of Physician – Clinical Quality

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6.1 LICENSURE --- Physician shall ensure that every physician providing Covered Services and employed or engaged by Physician or Subcontractor shall retain at all times during the period of this Contract a valid license to practice medicine issued by the Medical Board of the State of California, without restriction to practice in designated field of medicine.

6.2 HEALTH EDUCATION AND PREVENTION --- Physician shall inform Members of contributions which they can make to the maintenance of their own health and the proper use of health care services and have a program of health education and prevention (HEP) available in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. Physician shall:

6.2.1 Coordinate and integrate with CalOptima's QI Program;
6.2.2 Refer Members to appropriate HEP, based on the Member's needs;
6.2.3 Implement and utilize the Staying Healthy Assessment Tool as defined in CalOptima Policies; and,
6.2.4 Educate Providers and Members regarding Health Education services available to Members.

6.3 CLINICAL LABORATORY IMPROVEMENT AMENDMENTS --- Physician shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

6.4 QUALITY IMPROVEMENT PROGRAM --- Physician shall participate and cooperate in CalOptima's Quality Improvement Program. Physician shall establish, maintain and operate a Quality Improvement Program, in accordance with the delineation of responsibilities in the Delegation Agreement, which shall include an Annual Program Plan, Work Plan, and Annual Evaluation of Effectiveness of the QI program, which are consistent with current industry standards, Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), Joint Commission, and DHCS, and meets the requirements of CalOptima's Quality Improvement Program. Physician shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of Healthcare Effectiveness Data and Information Set (HEDIS)). Physician shall submit reports related to Quality Improvement as required by CalOptima Reporting Policy or otherwise required by DHCS. Physician shall adopt a detailed written Quality Improvement (QI) Plan, which shall include:

6.4.1 Well defined goals and objectives of the QI Program;

6.4.2 A well-defined scope of the QI Program that considers all different types and levels of care and service provided to Members; and

6.4.3 Clearly defined accountability and responsibility for the QI Program.

6.4.4 The Board of Directors of the Physician or a multi-disciplinary QI Committee designated by the Board of Directors of Physician shall oversee the QI Program conducted by Physician. This committee shall be separate from the Utilization Review committee (though members may be the same) and have a separate agenda. The QI Committee shall have adequate representation from Physician. The QI Committee shall meet at least on a quarterly basis. Physician shall maintain attendance records and meeting minutes related to the QI Program.

6.4.5 The QI Program activities shall be reported in writing to Physician's Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

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6.4.6 Physician's QI Program shall include involvement and participation in network-wide studies/projects initiated by CalOptima.

6.4.7 Physician shall develop an annual QI work plan, which includes the following:

6.4.7.1 Goals, scope and planned projects for the year;

6.4.7.2 Planned monitoring of identified issues and tracking these issues over time;

6.4.7.3 Planned studies/audits suggested by CalOptima or Physician; and

6.4.7.4 An annual evaluation of the QI Program/Plan.

6.4.8 Physician shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans, and reassessing the same data for improvement.

6.4.9 Requirements for the Physician's QI Program shall be established by the Physician's QI Committee and requirements may change based on changes in industry standards. CalOptima's QI Committee shall notify Physician of any additional changes in QI standards and requirements that shall be incorporated in Physician's QI Program. Physician shall not be required to change QI Program requirements more frequently than once per year.

6.4.10 Physician shall report findings and actions taken as a result of the quality improvement activities to CalOptima at least quarterly. In addition, Physician shall provide, upon request, summaries of QI Committee meetings, findings following review of specific cases and other reviews to CalOptima.

6.4.11 Physician shall respond promptly to all of CalOptima's requests for: (a) Medical Records; or (b) written responses to quality of care issues or Member complaints.

6.4.12 Physician shall allow CalOptima to use performance data for various program purposes, but not limited to, quality improvement activities, public reporting to consumers, and cost sharing for quality improvement activities, as identified in CalOptima Policy.

6.4.13 Physician agrees that CalOptima may make publicly available, as frequently as CalOptima deems necessary, reports of Physician's compliance with the Contract's requirements and performance metrics, including Members' access to care, the quality of care received by Members, and Physician's other performance trends, as applicable to Physician's obligations hereunder.

6.4.14 As long as CalOptima's disclosures under this Section 6.4 otherwise comply with applicable laws, no CalOptima disclosure under this Section 6.4 shall constitute a breach of this Contract

6.5 CASE MANAGEMENT SERVICES --- Physician shall offer a comprehensive Case Management Services program that targets medically and socially complex Members in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. The Case Management Services program shall consider the Member as a whole individual taking into consideration not only his/her medical needs but also the individual in context of cultural values, age, disability and self-determination.

6.5.1 Physician shall develop and implement policies and procedures that outline processes to

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support Case Management Services including but not limited to:

6.5.1.1 Pro-active identification mechanisms of high risk Members;

6.5.1.2 Referral processes;

6.5.1.3 Triage mechanisms with appropriate time frames;

6.5.1.4 Comprehensive assessment processes and formats;

6.5.1.5 Care plan development and care plan implementation guidelines and format;

6.5.1.6 Carve-out service coordination;

6.5.1.7 Documentation and communications processes for all Case Management Services; and

6.5.1.8 Mechanism for evaluation of Case Management Program outcomes.

6.5.2 Physician Case Management Services shall demonstrate the ability to find, receive, and process referrals for Covered Services and Urgent Care Services of Members who meet one (1), or more of the following conditions:

6.5.2.1 Are medically complex, demonstrate an inability to manage their medical condition and are at risk of exacerbation without intervention;

6.5.2.2 Demonstrate high recidivism;

6.5.2.3 Are chronically ill;

6.5.2.4 Have a catastrophic diagnosis;

6.5.2.5 Have inadequate family/community support;

6.5.2.6 Are cost and/or length of stay outliers;

6.5.2.7 Are receiving six (6) or more chronic medications per month;

6.5.2.8 Are transitioning between Providers that may cause continuity of care, concerns; and

6.5.2.9 Are Members with Special Health Care Needs.

6.5.3 CalOptima shall be entitled to periodically review Physician's Case Management Services program to determine compliance with Case Management Services standards. Physician shall furnish Case Management Services records and information to CalOptima upon request.

6.5.4 Physician Case Management shall collaborate with CalOptima on cases identified by CalOptima as needing care coordinator interventions.

6.5.5 As a component of the Case Management requirements in this Contract, Physician shall assure that Physician possesses adequate information management systems and capabilities to support Case Management functions and to meet guidelines established by CalOptima in CalOptima Policies.

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6.6 OBLIGATION OF PHYSICIAN UPON TERMINATION OF CONTRACTED PROVIDERS --- Physician shall ensure continuity and coordination of care by notifying Members affected by the termination of a Provider or practice site, and assisting them in selecting a new PCP or PCP site. Physician shall notify Members affected by the termination of a PCP or PCP site at least thirty (30) calendar days prior to the effective termination date, and assist them in selecting a new PCP or PCP site. Physician shall notify Members being seen regularly by a specialist or specialty group whose contract is terminated at least thirty (30) calendar days prior to the effective termination date and assist them in selecting a different Provider or site. Physician shall obtain the prior written approval of CalOptima before furnishing such notice, as CalOptima must obtain written approval of DHCS as to form and content. When a Provider's contract is discontinued, and either the Provider or Physician decides to terminate the contract for reasons other than professional review actions; or the Member is seeing one (1) Provider within a group and that Provider discontinues with Physician, but the rest of the group continues its contract with Physician, then Physician shall allow Members to have continued access to that Provider under the following circumstances:

6.6.1 Members undergoing active treatment for a chronic or acute medical condition (in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes) have access to their discontinued Provider through the current period of active treatment or for up to ninety (90) calendar days, whichever is shorter; and

6.6.2 Members in their second (2nd) or third (3rd) trimester of pregnancy have access to their discontinued Provider through the postpartum period.

6.7 WHOLE CHILD MODEL PROGRAM ---

6.7.1 WHOLE CHILD MODEL PROGRAM COMPLIANCE --- Effective July 1, 2019 or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall be responsible for identifying children with qualifying medical and surgical conditions and coordinating appropriate referrals of children with CCS Eligible Conditions as defined in Title 22, CCR Sections 41515.2 through 41518.9 and agrees to implement the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

6.7.1.1 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program

6.7.1.2 To ensure consistency in the provision of CCS Covered Services, Physician shall use all current and applicable CCS Program guidelines, including CCS Program regulations, CCS Program information notices, and CCS numbered letters in developing criteria for use by Physician's Medical Director or equivalent, and other care management staff. When applicable CCS clinical guidelines do not exist, Physician shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Member's CCS Eligible Condition.

The CCS numbered letters are posted by DHCS at the following web address for guidance on providing CCS Covered Services to Members eligible for CCS:

http://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx

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6.7.1.3 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall be responsible for all available Medically Necessary Medi-Cal services that are Covered Services under the CalOptima Medi-Cal Program. Any Medically Necessary CCS Services not available as a CalOptima Medi-Cal Covered Service shall remain the responsibility of the State and the county.

6.7.2 CCS PROVIDER NETWORK --- Physician shall utilize only CCS-Paneled Providers to treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment. Physician shall include in their network an adequate number of CCS Providers able to serve the needs of Members with CCS Eligible Conditions and receive timely access. Physician's network shall include an adequate number of CCS-Paneled Providers who are board-certified in both pediatrics and the appropriate pediatric subspecialty conditions to treat a CCS Eligible Condition. However, Members cannot be limited to a single delegated entity's provider network. Physician must ensure Members have access to all Medically Necessary CCS-Paneled Providers within CalOptima's provider network. In addition, Physician may use an out-of-state Provider, in accordance with APL 17-019, if an in-state CCS Provider does not possess the clinical expertise to appropriately treat the Member's CCS condition. If no in-network CCS-Paneled Provider possesses the clinical expertise to appropriately treat a Member's CCS condition, then CCS delegated Physician shall arrange and pay for, and coordinate the provision of, the Medically Necessary Covered Services to the Member by one or more out-of-network CCS-Paneled Providers who possess the appropriate knowledge and clinical experience. CCS delegated Physician shall implement procedures to identify individuals who may need or who are receiving services from Out-of-Network Providers and/or programs in order to ensure coordinated service delivery and efficient and effective joint case management.

6.7.3 CCS PROVIDER CREDENTIALING --- Physician shall credential CCS Providers in accordance with the existing credentialing requirements along with the requirements of APL 18-011. DHCS will retain responsibility for paneling CCS specialists. In addition, CCS Providers shall be able to utilize CalOptima's provider grievance process.

6.7.4 COVERED CCS SERVICES --- In addition to other services required to be provided to Members under this Contract, effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall cover CCS Services for Members determined to be eligible in accordance with the CCS Program medical eligibility regulations. Upon diagnostic evidence that a Member under 21 years of age may have a CCS Eligible Condition, Physician shall refer the Member to the county CCS office for eligibility determination.

6.7.4.1 Physician shall ensure assessment and care coordination for the transition of Members who are eligible for CCS Services and receiving services through the CCS Program at the time of the transition.

6.7.4.2 For the identification of Members eligible for CCS Services, Physician shall ensure the following:

6.7.4.2.1 Participating Providers shall perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that a Member has a CCS Eligible Condition.

6.7.4.2.2 Initial referrals of Members with CCS Eligible Conditions shall be made to CalOptima by telephone, same day mail, or fax or other secure electronic system, and CalOptima will submit the referral and medical

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documentation to the County CCS Program for eligibility determination. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the county CCS Program.

6.7.4.2.3 Physician shall provide all Medically Necessary CCS Services for the Member's CCS Eligible Condition(s).

6.7.4.2.4 If the County denies CCS Program eligibility for a Member referred by Physician, Physician remains responsible for the provision of all Medically Necessary Covered Services to the Member, including EPSDT services.

6.7.5 CONTINUITY OF CARE --- Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide continuity of care to CCS-eligible Members transitioning to the Whole Child Model Program in accordance with Welfare and Institution Code Sections 14094.13, Health and Safety Code, Section 1373.96, APL 18-011, and as follows:

6.7.5.1 In accordance with Welfare and Institutions Code, Section 14094.13(a)-(d), Physician must allow for continuity of care between Members eligible for CCS Services and CCS Providers, and Providers of Specialized Durable Medical Equipment, with whom there is an existing relationship for up to 12 months after the transition. At its discretion, Physician may extend the continuity of care period beyond the 12 months specified in this Section.

6.7.5.2 For out-of-Network CCS Providers and Providers of Specialized Durable Medical Equipment, Physician must allow for continuity of care under the following conditions:

6.7.5.2.1 The Member has seen the CCS Provider for a non-emergency visit at least once during the 12 months immediately preceding their transition to CalOptima's Whole Child Model Program or the Member has previously received Specialized Durable Medical Equipment from a DME provider.

6.7.5.2.2 The CCS Provider or Provider of Specialized Durable Medical Equipment accepts Physician's rate for the service, or the applicable Medi-Cal or CCS fee-for-service rate, whichever is higher, unless the CCS Provider enters into an alternative payment methodology mutually agreed upon by Physician and the CCS Provider.

6.7.5.2.3 Physician confirms that the CCS Provider meets applicable CCS standards and has no disqualifying quality of care issues.

6.7.5.2.4 The CCS Provider or the Provider of Specialized Durable Medical Equipment makes treatment information available to Physician, to the extent authorized by the State and federal patient privacy provisions.

6.7.5.3 Ensure that the continuity of care requirements for pharmaceutical services and provision of prescribed drugs are applied to Members who are eligible for the CCS Program at the time of the transition to the Whole Child Model Program. Before the previously prescribed drug is discontinued, Physician and the Member's prescribing CCS Provider shall complete the necessary evaluation and treatments and must both agree that the previously prescribed drug is no longer

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Medically Necessary, or that it is no longer prescribed by the Member's prescribing CCS Provider.

6.7.6 EPSDT SERVICES --- Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, for CCS-eligible Members, Physician shall provide all Medically Necessary Covered Services, including EPSDT services when the scope of an EPSDT benefit is more generous than the scope of a CCS benefit. In such cases, Physician shall apply the EPSDT standard of what is Medically Necessary to correct or ameliorate the Member's condition.

6.7.7 CASE MANAGEMENT AND COORDINATION OF CARE --- Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide service authorization, case management, and care coordination for CCS Services by an employee or Subcontractor with knowledge or adequate training on the CCS Program, and clinical experience with either the CCS population or pediatric patients with complex medical conditions.

6.7.7.1 Once a Member's eligibility for the CCS Program is established, CalOptima shall complete the risk level and needs assessment required under APL 18-011. Physician shall provide Complex Case Management services to all Members eligible for CCS Services and coordinate care between the Primary Care Provider, CCS specialty services, and if applicable Outpatient Mental Health Services and regional center services across all settings. The provision of Complex Case Management shall include the facilitation of communication between the Member's health care Providers, personal care Providers such as IHSS and behavioral health Providers, and when appropriate, the Member and/or Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.2 Physician shall also arrange referral to Specialty Mental Health, and Drug Medi-Cal services as appropriate through the county substance use disorder program if determined necessary through CalOptima's assessment. To arrange services with a regional center, Physician shall:

6.7.7.2.1 Coordinate with Members eligible for CCS Services and their parents, custodial parents, legal guardians, or other authorized representatives, in understanding and accessing services; and

6.7.7.2.2 Operate as a central point of contact for questions regarding access, care, and problem resolution.

6.7.7.3 Physician shall create an individual care plan (ICP) for CCS-eligible Members who have been determined high risk through the CalOptima risk stratification process, incorporate the required elements stated in Welfare and Institutions Code, Section 14094.11(c) and APL 18-011, be specific to individual Member needs, and update the ICP at least annually.

6.7.7.4 Provide Person-Centered Planning, case management and coordination of care, to Members eligible for CCS Services and in collaboration with the Member's parents, custodial parents, legal guardians, or other authorized representatives.

6.7.7.5 Provide information to Members eligible for CCS Services on how to access local family resource centers or family empowerment centers.

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6.7.7.6 Allow a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request continuing case management and care coordination from their public health nurse within 90 days of transitioning to the Whole Child Model Program, in accordance with Welfare and Institutions Code, Section 14094.13(e). If the county public health nurse leaves the CCS Program or is no longer available to provide case management and care coordination, Physician shall transition those services to one of its case managers who has received adequate training on the CCS Program and has clinical experience with the CCS population or pediatric patients with complex medical conditions.

6.7.8 RIGHTS FOR MEMBERS ELIGIBLE FOR CCS ---

6.7.8.1 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall provide a mechanism for a Member eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, to request a Specialist or clinic as a Primary Care Provider.

6.7.8.2 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, for Members receiving continuity of care, Physician shall send a written notice 60 days prior to the end of the authorized continuity of care period. The notice shall explain the right to petition Physician for an extension of the continuity of care period, the criteria used to evaluate the petition, and the appeals process if Physician denies the petition.

6.7.8.3 In addition to the Member's right to file a Grievance or request an appeal or State Fair Hearing, effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall also ensure that Members who are eligible for CCS Services, or the Member's parents, custodial parents, legal guardians, or other authorized representatives, may appeal the continuity of care limitations, or the extension of a continuity of care period in accordance with Welfare and Institutions Code, Section 14094.13(i)(1).

6.7.8.4 Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, Physician shall also ensure that CCS-eligible Members, or the Members' parents, custodial parents, legal guardians, or other authorized representatives, retain the right to request an Appeal and State Fair Hearing for adverse benefit determinations that involve delay, modification, denial, or discontinuation of CCS Services in accordance with CalOptima Policy.

6.7.8.5 Physician must ensure Members are provided information on grievances, appeals and State Fair Hearing processes as provided under CalOptima Policies. Effective July 1, 2019, or such later date as Physician shall begin Participating in the CalOptima Whole Child Model Program, CCS-Eligible Members enrolled in managed care are provided the same grievance, appeal and State Fair Hearing rights as provided under APL 18-001, and State and Federal law.

6.8 CREDENTIALING REQUIREMENTS --- Physician acknowledges and agrees that CalOptima has delegated credentialing and recredentialing obligations to Physician. Physician shall have an ongoing credentialing and recredentialing program covering Participating Providers (e.g. Practitioners, organizational providers and licensed independent practitioners) consistent with CalOptima Policies and in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement. Physician shall comply with all credentialing and recredentialing obligations as specified in this Contract and CalOptima Policies.

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6.8.1 Physician shall have a mechanism in place to ensure confidentiality of information collected during the credentialing and recredentialing process.

6.8.2 Physician shall ensure that all Participating Providers who furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's credentialing and recredentialing requirements as specified in CalOptima's Credentialing and Recredentialing Policy. Physician shall ensure that any Participating Provider who is required to meet credentialing and recredentialing requirements, but fails to do so, does not furnish items and/or services and/or receive reimbursement for any Covered Services furnished to Members. Physician shall ensure that all contracts with Participating Providers who are subject to these requirements allow for termination of the Participating Provider's right to furnish items and/or services to Members and/or submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.8.3 Physician shall provide to CalOptima or have available for CalOptima review upon request the following:

6.8.3.1 An accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHS-6216 (07/05), or such other disclosure form as DHCS may otherwise provide to meet the requirements of Section 51000.35 of Title 22 of the California Code of Regulations.

6.8.3.2 A signed attestation that all Participating Providers who are required to meet CalOptima Minimum Standards in order to furnish, submit claims and/or receive reimbursement for Covered Services furnished to Members meet CalOptima's Minimum Standards as specified in CalOptima Policies.

6.8.3.3 An annual signed attestation that all Participating Providers are credentialed to the standards set forth by CalOptima and DHCS.

6.8.3.4 Monthly summary of all credentialing and recredentialing activity including the name of Participating Provider, date of facility site review (if applicable) and decision date.

6.8.3.5 Concurrent reporting of any adverse action toward a Participating Provider, including adverse actions reported to a governmental or other regulatory agency.

6.8.3.6 Not Applicable to this Contract.

6.9 BOARD CERTIFICATION --- --- Physician shall ensure that all Practitioners furnishing Covered Services to Members meet those requirements identified in CalOptima Policy regarding Board Certification.

6.9.1 Physician shall ensure that any Practitioner who is required to meet the requirements set forth above, but fails to do so, does not furnish items and/or services to Members, submit claims and/or receive reimbursement for any Covered Services furnished to Members. Physician shall ensure that all contracts with Practitioners who are subject to these requirements allow for termination of the Practitioners' right to furnish items and/or services, submit claims and/or receive reimbursement for Covered Services furnished to Members.

6.9.2 Physician acknowledges that these requirements apply to each individual Practitioner that is affiliated with and/or part of any medical group, independent physician associations

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(IPA) and/or other organization or entity that contracts with Physician to furnish Covered Services to Members.

6.10 FACILITY SITE/MEDICAL RECORDS REVIEW (FSR/MRR) --- Physician shall participate in collaborative PCP site reviews for shared PCPs in accordance with MMCD Policy Letter specifications and other requirements of DHCS. Physician shall comply with CalOptima Policies related to PCP site reviews including those addressing collaborative programs.

6.11 COORDINATION AND CONTINUATION OF CARE --- Physician shall have systems in place to ensure managed patient care, including at a minimum:

6.11.1 Management and integration of health care, including Covered Services, through a PCP.

6.11.2 Referrals for Medically Necessary specialty, secondary and tertiary Covered Services.

6.11.3 Physician shall clearly specify referral requirements to Participating Providers and Subcontractors and establish a system to track and monitor services requiring prior authorizations through the Physician.

6.11.4 Physician shall have a utilization management program that meets guidelines as set forth in CalOptima Policies and is in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement.

6.11.5 Systems to assure provision of care in emergency situations, including an education process to help assure that Members know where and how to obtain Medically Necessary Covered Services in emergency situations.

6.11.6 The provision of Case Management Services as set forth in this Contract, CalOptima Policies and in coordination with CalOptima's Case Management program.

6.11.7 Systems for the consideration and approval of standing referrals, in accordance with CalOptima Policy.

6.11.8 Physician shall be responsible for coordinating care of certain services including:

6.11.8.1 Participating Providers providing Pediatric Preventive Services (CHDP) shall document such services on the CMS-1500, UB-04 claim form or electronic equivalent.

6.11.8.2 Participating Providers providing CHDP agree to coordinate with the Orange County CHDP Program as set forth in the CHDP Program pursuant to CalOptima's Pediatric Preventative Services Policy;

6.11.8.3 Physician shall promote education and support systems that increase compliance with the standards for periodicity and content of pediatric health assessments;

6.11.8.4 Physician shall make referrals to the Women, Infants and Children Food Supplementation Program (WIC) in accordance with WIC policies and procedures;

6.11.8.5 Physician shall make referrals for perinatal Members to the PSS program pursuant to CalOptima Policy;

6.11.8.6 Physician shall make referrals to the Regional Center of Orange County (RCOC), as set forth in the RCOC MOU;

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6.11.8.7 All Members between the ages of three (3) and twenty-one (21) shall be referred to a dentist in accordance with the most recent recommendations of the AAP, as part of periodic health assessment;

6.11.8.8 Physician shall be responsible for Covered Services that are related to dental services but are not provided by a dentist or dental anesthetists. Covered Services required for a dental procedure include but are not limited to: laboratory services, pre-admission physical examinations required for admission to inpatient and outpatient Facility, anesthesia services, and inpatient surgical services and inpatient hospitalization services as provided in CalOptima Policy. Physician shall develop referral and prior authorization policies and procedures to implement the above requirements. Physician shall submit these policies to CalOptima for review and approval;

6.11.8.9 Physician shall provide outpatient mental health services within the PCP's scope of practice. Physician shall refer Members requiring inpatient mental health services to the Orange County Health Care Agency (HCA) Behavioral Health Services. Physician shall retain financial responsibility for initial physical health assessment for any Member admitted to an inpatient facility. This assessment shall be performed by a facility physician or by the Member's PCP. Physician shall also maintain financial responsibility for any Covered Services that are Medically Necessary while Members are receiving inpatient care including but not limited to laboratory and/or x-ray services.

6.11.8.10 Mental Health Services. Physician shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. This would include the coordination and responsibility for non-mental health services for Members undergoing inpatient psychiatric treatment. CalOptima shall retain financial responsibility for certain mental health psychotherapeutic drugs. Physician shall retain financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. Physician shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU;

6.11.8.11 For Outpatient Mental Health Services, Physician shall refer Members to the CalOptima Behavioral Health for mild to moderate mental health conditions and the Administrative Service Organization (ASO) for Specialty Mental Health services.

6.11.8.11.1 To access mild to moderate Outpatient Mental Health Services that are outside the PCP's scope of practice, Physician shall refer Members to CalOptima's mental health contracted provider through CalOptima Behavioral Health. Members requiring alcohol and or substance use disorder treatment should be referred to the Orange County Drug Medi-Cal Organized Delivery System (DMC-ODS).

6.11.8.12 For outpatient Specialty Mental Health Services, Physician shall refer Members to the Administrative Service Organization (ASO) contracted by Orange County to provide assessment, referral and authorization services for Specialty Mental Health Services.

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6.11.8.12.1 Physician shall provide Care Management Services for the Member's physical health needs and coordinate Covered Services with Specialty Mental Health Providers. DHCS retains financial responsibility for certain mental health psychotherapeutic drugs. Physician shall retain financial responsibility for laboratory tests associated with provision of mental health services, including but not limited to use of psychotropic drugs. Physician shall comply with all responsibilities, policies and procedures as set forth in the HCA/MHP MOU; and

6.11.8.12.2 Physician shall arrange and coordinate Medically Necessary Covered Services, including referral of Members requiring alcohol and drug treatment to Orange County DMC-ODS. Members requiring outpatient heroin detoxification shall be referred to appropriate Providers.

6.11.9 To the extent that the Physician is responsible for the coordination of care for Members, CalOptima shall share with Physician, in accordance with Section 14.12, any utilization data that DHCS has provided to CalOptima, and Physician shall receive the utilization data provided by CalOptima and use it as the Physician is able for the purpose of Member care coordination.

6.12 VACCINES --- Physicians shall assure, at a minimum, all routine pediatric vaccinations currently recommended by the AAP/ACIP and the United States Preventative Task Force and additional routine immunizations are provided to Members consistent with Physician's immunization policy. CalOptima shall not reimburse Physician for the cost of vaccines that are available under the Vaccines for Children (VFC) program. Providers administering pediatric immunizations shall maintain an appropriate supply of vaccines from the VFC program. Vaccinations, which are not part of the standard pediatric protocol, shall be administered according to CalOptima Policies.

6.13 PHARMACY APPROVED DRUG LIST COMPLIANCE --- Participating Providers shall comply with the CalOptima Approved Drug List and its associated drug utilization and disease management guidelines and protocols. Requests for items not included in the Approved Drug List shall require prior authorization by CalOptima. The prescribing physician shall be responsible for submitting prior authorization requests and responding to requests for additional information in accordance with regulatory timeframes. The prescribing physician shall provide CalOptima all information necessary to process prior authorization requests.

6.13.1 Physician may be subject to sanctions for Participating Provider's failure to comply with the prior authorization process.

6.13.2 Participating Providers shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist.

6.14 RESEARCH --- Physician agrees to participate in and make data available for research projects initiated or approved by CalOptima.

6.15 FUNCTIONS AND DUTIES OF PHYSICIAN FOR SPD --- Physician shall provide the following for SPD Members:

6.15.1 INTENTIONALLY LEFT BLANK;

6.15.2 Physician shall refer all SPD Members, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system, to a contracted Evaluation

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Services Provider, and provide appropriate Covered Services in accordance with the resulting evaluation, pursuant to CalOptima Policy;

6.15.3 Physician shall make available Incontinence Supplies to SPD Members when such supplies are Medically Necessary to treat incontinence. Physician shall not restrict the Incontinence Supplies by brand name as long as the supplies do not exceed the rate paid for comparable supplies under the DHCS Medi-Cal Fee-for-Service program;

6.15.4 Physician shall authorize Medical Supplies for six (6) month periods for SPD Members under the following conditions: (a) the PCP determines that the SPD Member requires ongoing Medical Supplies; (b) Physician determines that the Medical Supplies are Medically Necessary based upon the prescribing PCP's assessment; and (c) the PCP projects that the SPD Member's need for the Medical Supplies will remain stable over the six (6) month period.

6.15.5 Physician or Subcontractor shall dispense Medical Supplies in no greater than thirty (30) calendar day amounts, even when such Medical Supplies are authorized for six (6) month periods. Physician shall approve re-authorization of Medical Supplies at consecutive six (6) month intervals unless a PCP determines that a change in the SPD Member's medical condition warrants additional assessment, and/or adjustments to the prescription for Medical Supplies. Notwithstanding a six (6) month authorization, Physician shall not be responsible for providing Medical Supplies when the SPD Member's Medi-Cal eligibility ceases or when the Member is no longer enrolled with the Physician;

6.15.6 Physician shall permit SPD Members to select as a PCP any Participating Specialist Provider willing to perform the role of the PCP. Physician shall provide to all SPD Members upon enrollment with Physician and at any time thereafter, upon the SPD Member's request, a list of all Participating Specialist Providers willing and available to perform duties/functions of the PCP;

6.15.7 Within one-hundred twenty (120) days upon enrollment with Physician of an SPD Member, Physician shall complete a plan of care pursuant to CalOptima Policies. Physician shall update this plan as appropriate and/or annually. Physician shall consult the SPD Member and/or Member's representative as appropriate in completing and updating the plan of care;

6.15.8 Upon request, and as Medically Necessary, for any qualifying SPD Member as defined in CalOptima Policies enrolled with Physician, Physician shall conduct and provide, when appropriate, a home assessment to assess the SPD Member's needs for appropriate referrals to Participating Providers and/or community based organizations and providers;

6.15.9 Physician shall provide SPD Members with standing referrals pursuant to CalOptima Policies, to specialists necessary for conditions requiring ongoing treatment or ongoing supply, equipment or DME service needs. These referrals can be renewed semi-annually; and

6.15.10 Physician shall have Participating Providers with facilities and/or sites that are capable of accommodating SPD Members with special medical care needs as defined in CalOptima Policies. Facility requirements to meet the needs of SPD Members with special medical care needs include, but are not limited to, office or clinic equipment to facilitate the appropriate and safe examination of SPD Members and the capacity to provide specific Covered Services to SPD Members, such as the provision of dental procedures under general anesthesia.

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6.15.11 If Physician's network is unable to provide necessary medical services covered under the Contract to a particular SPD Member, Physician must adequately and timely cover these services out-of- network for the Member, for as long as the entity is unable to provide them. Physician acknowledges that out-of-network providers must coordinate with Physician with respect to payment, and Physician shall ensure that such out-of-network providers understand this requirement. Physician must ensure that cost to the Member is not greater than it would be if the services were furnished within the network. Physician shall provide for the completion of covered services by a terminated or out-of-network provider at the request of a Member, in accordance with the continuity of care requirements in Health and Safety Code Section 1373.96. For newly-enrolled SPD Members, Physician shall provide continued access for up to twelve (12) months to an out-of-network provider with whom the Member has an ongoing relationship (i.e. an existing provider from whom they are receiving services), if the provider will accept Physician or Medi-Cal FFS rates, whichever is higher per W & I Code 14182(b)(13) and (14). An ongoing relationship shall be determined by identifying a link between the newly-enrolled SPD Member and an out-of-network provider using FFS utilization data provided by DHCS.

6.15.12 For SPD Members, Physician shall report all grievances related to those listed in Title 28, CCF, Section 1300.68(f)(2)(D), including, but not be limited to, timely assignments to a provider, issues related to cultural and linguistic sensitivity, difficulty with accessing specialists, and grievances related to out-of-network requests.

6.15.13 Physician and Participating Providers and all staff who interact with SPD Members, as well as those who may potentially interact with SPD Members, or any other staff deemed appropriate by CalOptima or DHCS shall receive sensitivity training as provided by CalOptima or DHCS, or by Physician pursuant to DHCS requirements and CalOptima Policies.

6.15.14 Personal Care Coordinator (PCC) Programs for CCS and SPD Members Definitions:

6.15.14.1 "Care Management Monthly Profile (Profile)" is a monthly report generated by CalOptima which provides the healthcare risk outcomes for CCS and SPD Members.

6.15.14.2 "Individual Care Plan" is a plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.

6.15.14.3 "Personal Care Coordinator or PCC" is a dedicated non-licensed care coordinator, assigned to each Medi-Cal member with an CCS Eligible Condition as determined by the local CCS Program, or SPD aid code, supervised by a licensed person, and funded by CalOptima.

6.15.14.4 Physician shall employ PCCs and participate in all PCC Program requirements as defined in CalOptima Policy and the Profile. Physician shall staff one PCC per six hundred (600) CCS or SPD Members assigned to Physician. PCC responsibilities include but are not limited to: Assisting Members and Member's PCPs in the development of an Individual Care Plan (ICP); communicating the ICP with the Member, Member's PCP and Member's care team; and assisting Members receiving care as outlined in the ICP. Physician shall submit required reports and documents to CalOptima. These include but are not limited to ICPs, PCC staffing levels, and PCC and professional staff descriptions to demonstrate adherence CalOptima Policy requirements.

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6.15.14.5 CalOptima shall provide Physician the Profile requirements. Changes to the Profile which may impact PCC supplemental capitation, will be communicated to Physician thirty (30) days prior to the effective date of such change. If Physician is unable to agree to the requirements stipulated in the Profile, and no resolution is reached in the thirty (30)-day period, further action may be taken including but not limited to recoupment of PCC supplemental funds that have been paid to Physician and termination of the Contract.

6.16 ADVANCE DIRECTIVES --- Physician shall maintain written policies and procedures related to Advanced Directives in compliance with current State law. Physician shall not discriminate against any Member on the basis of that Member's Advance Directive status.

6.17 SECOND OPINIONS --- Physician shall provide, at its sole cost and expense, second opinions and provide to Members all required notification, documentation, forms and information regarding obtaining second opinions as prescribed by CalOptima Policies.

6.18 DISEASE MANAGEMENT --- Physician shall assist CalOptima in implementation of a disease management program in accordance with the delineation of responsibilities in the Delegation Acknowledgement and Acceptance Agreement.

6.19 MEMBERS WITH SPECIAL HEALTH CARE NEEDS --- Physician shall identify, assess and implement care plans as appropriate for Members with Special Health Care Needs. The Physician shall have processes for monitoring and tracking Members with Special Health Care Needs and the provision of services under the implemented plan of care.

6.20 MEMBER VISITS --- Physician shall ensure that Subcontracting health facilities licensed pursuant to Health and Safety Code Section 1250 permit a Member at Member's choice to be visited by a Member's domestic partner, the children of a Member's domestic partner, and the domestic partner of the Member's parent or children. Physician shall include the requirement of this Section in its Subcontracts with such health facilities.

6.21 DHCS DIRECTIONS --- If required by DHCS, Physician and its Subcontractors shall cease specified activities, which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

6.22 Intentionally Left Blank.

6.23 ENHANCED CARE MANAGEMENT

6.23.1 Physician Participation in CalOptima ECM – Physician shall begin participating as an ECM Provider in CalOptima Enhanced Care Management, as set forth below, for CalOptima Members who meet the DHCS-defined criteria for one of the following Populations of Focus ("ECM Populations of Focus"):

6.23.1.1 For CalOptima adult Members who meet the DHCS-defined criteria for one of the following: (i) Individuals Experiencing Homelessness; (ii) "Individuals At Risk for Avoidable Hospital or ED Utilization (formerly known as "High utilizer"); (iii) Individuals with Serious Mental Illness ("SMI") and/or Substance Use Disorder ("SUD") Needs; (iv) Individuals Transitioning from Incarceration; (v) Individuals with Intellectual or Developmental Disabilities ("I/DD"); or (vi) Pregnancy, Postpartum, and Birth Equity Population of Focus.

6.23.1.2 Effective January 1, 2023, or such later date as determined by DHCS, for CalOptima Members who meet the DHCS-defined criteria for one of the

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following: (i) Adults Living in the Community and At Risk for Long Term Care (LTC) Institutionalization; or (ii) Adult Nursing Facility Residents Transitioning to the Community.

6.23.1.3 Effective July 1, 2023, or such later date as determined by DHCS, for other CalOptima children and youth who meet the DHCS-defined criteria for one of the following: (i) Individuals Experiencing Homelessness; (ii) "Individuals At Risk for Avoidable Hospital or ED Utilization (formerly known as "High utilizer"); (iii) Individuals with SMI and/or SUD Needs; (iv) Individuals Transitioning from Incarceration; (v) Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition; (vi) Children and Youth Involved in Child Welfare (including foster care up to age 26); or (vii) Pregnancy, Postpartum, and Birth Equity Population of Focus.

6.23.1.4 Effective January 1, 2024, or such later date as determined by DHCS, for Members who meet the DHCS-defined criteria for one of the following: (i) Pregnancy, Postpartum, and Birth Equity Population of Focus (who are subject to racial and ethnic disparities).

6.23.2 Physician as an ECM Provider – Physician shall be responsible for providing ECM services as the Member's ECM Provider. ECM Provider shall ensure its systems and infrastructure are in place to provide ECM services to ECM Members. ECM Provider shall implement ECM in compliance with this Contract and CalOptima Policies.

6.23.3 ECM Provider Requirements – Physician, as an ECM Provider, shall satisfy the ECM Provider requirements as set forth in CalOptima Policies and as follows:

6.23.3.1 ECM Provider shall be experienced in serving the ECM Population(s) of Focus it will serve and shall have experience and expertise with the services it will provide.

6.23.3.2 ECM Provider shall comply with all applicable State and federal laws and regulations and all ECM requirements in the DHCS-CalOptima ECM and Community Supports Contract and associated guidance.

6.23.3.3 ECM Provider shall have the capacity to provide culturally appropriate and timely in-person care management activities including accompanying Members to critical appointments when necessary. ECM Provider shall be able to communicate in culturally and linguistically appropriate and accessible ways.

6.23.3.4 ECM Provider shall have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health Providers, Specialists, and other entities, including Community Supports Providers, to coordinate care as appropriate to each Member.

6.23.3.5 ECM Provider shall use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of an ECM Member care plan that can be shared with other Providers and organizations involved in each ECM Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital, long-term care facility, housing status).

6.23.3.6 If a State-level enrollment pathway exists, ECM Provider shall enroll as a Medi-Cal Provider, pursuant to relevant DHCS APLs including APL 19-004: Provider

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Credentialing/ Recredentialing and Screening/Enrollment. If APL 19-004 does not apply to an ECM Provider, the ECM Provider shall comply with CalOptima's process for vetting the ECM Provider, which may extend to individuals employed by or delivering services on behalf of the ECM Provider, to ensure it can meet the capabilities and standards required to be an ECM Provider.

6.23.4 Identifying Members for ECM – Physician, which also serves as the ECM Provider, shall proactively identify Members who would benefit from ECM and determine on a case by case basis whether identified Members are eligible for ECM in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach.

6.23.5 Member Assignment to ECM Provider

6.23.5.1 CalOptima shall be responsible for making ECM authorization determinations for Physician's enrolled Members in accordance with applicable CalOptima Policies.

6.23.5.2 Physician shall serve as the ECM Provider for all ECM Members enrolled in the Physician, except as otherwise provided in Section 6.23.5.3 of this Contract.

6.23.5.3 Physician acknowledges and agrees that the County of Orange shall serve as the ECM provider for certain ECM Members as specified in CalOptima Policy GG.1356: Enhanced Care Management Administration. Physician shall fully cooperate and coordinate with CalOptima and with the County of Orange, serving as the ECM provider for such ECM Members, in accordance with applicable CalOptima Policies and/or as required by CalOptima to ensure compliance with DHCS requirements for ECM.

6.23.6 ECM Provider Staffing – At all times, ECM Provider shall have adequate staff to ensure its ability to carry out responsibilities for each assigned ECM Member consistent with this Contract, CalOptima Policies, DHCS ECM Provider Standard Terms and Conditions, the DHCS-CalOptima ECM and Community Supports Contract and any other related DHCS guidance.

6.23.7 ECM Provider Outreach and Member Engagement – ECM Provider shall be responsible for conducting outreach to each assigned Member and engaging each assigned Member into ECM, in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach. ECM Provider shall ensure outreach to assigned Members prioritizes those with the highest level of risk and need for ECM.

6.23.7.1 ECM Provider shall conduct outreach primarily through in-person interaction where Members and/or their family member(s), guardian, caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their community. ECM Provider may supplement in-person visits with secure teleconferencing and telehealth, where appropriate, with the Member's consent, and in compliance with CalOptima Policies. ECM Provider shall use the following modalities, as appropriate and as authorized by the Member, if in-person modalities are unsuccessful or to reflect a Member's stated contact preferences: (i) Mail; (ii) Email; (iii) Texts; (iv) Telephone calls; and (v) Telehealth.

6.23.7.2 ECM Provider shall comply with non-discrimination requirements set forth in State and federal law and this Contract.

6.23.7.3 CalOptima and ECM Provider will coordinate to ensure that Members who meet exclusionary criteria as defined in CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach do not receive ECM services.

6.23.8 Initiating Delivery of ECM – ECM Provider shall obtain, document, and manage Member authorization for the sharing of personally identifiable information between CalOptima and ECM, Community Supports, and other Providers involved in the provision of Member care to the extent required by federal law.

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6.23.8.1 Member authorization for ECM-related data sharing is not required for the ECM Provider to initiate delivery of ECM unless such authorization is required by federal law. When federal law requires authorization for data sharing, ECM Provider shall communicate that it has obtained Member authorization for such data sharing back to CalOptima.

6.23.8.2 ECM Provider shall notify CalOptima to discontinue ECM under the following circumstances: (i) The Member has met their care plan goals for ECM; (ii) The Member is ready to transition to a lower level of care; (iii) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or (iv) ECM Provider has not had any contact with the Member after three (3) attempts.

6.23.8.3 When ECM is discontinued, or will be discontinued for the Member, Provider is responsible for sending a notice of action notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the notice of action. ECM Provider shall communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex Case Management, Basic PHM, etc).

6.23.9 ECM Requirements and Core Service Components of ECM – ECM Provider shall ensure ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Medi-Cal Members assigned to the Physician. ECM Provider shall ensure the approach is person-centered, goal oriented, and culturally appropriate.

6.23.9.1 Subject to all applicable requirements set forth in this Contract (including, but not limited to, subcontracting requirements), if the ECM Provider subcontracts with other entities to administer ECM functions, the ECM Provider shall ensure agreements with each entity bind the entities to the terms and conditions set forth in Section 6.23 of this Contract and CalOptima Policies and that its Subcontractors comply with all requirements in DHCS ECM Provider Standard Terms and Conditions and the DHCS-CalOptima ECM and Community Supports Contract. Notwithstanding any subcontracting arrangements, ECM Provider shall remain responsible and accountable for any subcontracted ECM functions.

6.23.9.2 ECM Provider shall: (i) Ensure each Member receiving ECM has a Lead Care Manager; (ii) Coordinate across all sources of care management in the event that an ECM Member is receiving care management from multiple sources; (iii) Notify CalOptima to ensure non-duplication of services in the event that an ECM Member is receiving care management or duplication of services from multiple sources; and (iv) Follow CalOptima's instruction and participate in efforts to ensure ECM and other care management services are not duplicative.

6.23.9.3 ECM Provider shall collaborate with area hospitals, Primary Care Providers (when not serving as the ECM Provider), behavioral health Providers, Specialists, dental Providers, Providers of services for LTSS and other associated entities, such as Community Supports Providers, as appropriate, to coordinate Member care for ECM.

6.23.9.4 ECM Provider shall provide the following core service components of ECM to each assigned ECM Member in compliance with CalOptima Policies GG.1354: Enhanced Care Management – Eligibility and Outreach and GG.1353: Enhanced Care Management Service Delivery: (i) Outreach and engagement of Members into ECM (ii) Comprehensive assessment and care management plan; (iii) Enhanced coordination of care; (iv) Health promotion; (v) Comprehensive transitional care; (vi) Member and family supports; and (vii) Coordination of and referral to community and social support services.

6.23.9.5 ECM Provider shall ensure the establishment of an ECM Care Team and a communication process between Members' ECM Care Team participants related to

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services being rendered, in accordance with the requirements set forth in CalOptima Policies.

6.23.9.6 ECM Provider shall complete a health needs assessment and develop a comprehensive, individualized, person-centered care plan for each ECM Member. ECM Provider shall ensure case conferences are conducted by the ECM Care Team and the ECM Member's health needs assessment and care plan are updated as necessary.

6.23.10 Training – ECM Provider shall participate in all mandatory, Provider-focused ECM training and technical assistance provided by CalOptima, including in-person sessions, webinars, and/or calls, as necessary. ECM Provider shall ensure that its staff who will be delivering ECM services complete training required by CalOptima and DHCS prior to participating in the administration of the ECM services.

6.23.11 Data Sharing to Support ECM - CalOptima and ECM Provider agree to exchange available information and data as required by DHCS guidance and CalOptima Policies, including but not limited to notification of hospital emergency department visits, inpatient admissions and discharges, and health history of ECM Members. CalOptima and ECM Provider shall conduct such information and data sharing in compliance with all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements (including applying the minimum necessary standard when applicable), and other federal and California state laws and regulations. Further, ECM Provider shall establish and maintain a data-sharing agreement with other Providers that is compliant with all federal and California state laws and regulations as necessary. If applicable laws and/or regulations require an ECM Member's valid authorization for release of health information and a legal exception does not apply, ECM Provider may not release such information without the ECM Member's valid authorization.

6.23.11.1 CalOptima will provide to ECM Provider the following data at the time of assignment and periodically thereafter, and following DHCS guidance for data sharing where applicable: (i) Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider; (ii) Non-duplicative Encounter and/or claims data, as appropriate; (iii) Non-duplicative physical, behavioral, administrative and social determinants of health data (e.g., Homeless Management Information System (HMIS data)) for all assigned Members, as available; and (iv) Reports of performance on quality measures and/or metrics, as requested.

6.23.12 Claims Submission and Reporting – ECM Provider shall submit claims for the provision of ECM-related services to CalOptima using the national standard specifications and code sets to be defined by DHCS. In the event ECM Provider is unable to submit claims to CalOptima for ECM-related services using the national standard specifications and DHCS-defined code sets, ECM Provider shall submit an invoice to CalOptima with a minimum set of data elements (to be defined by DHCS) necessary for CalOptima to convert the invoice to an encounter for submission to DHCS.

6.23.13 Quality and Oversight – ECM Provider acknowledges that CalOptima will conduct oversight of ECM Provider's participation in ECM to ensure the quality of ECM and ongoing compliance with program requirements, which may include audits and/or corrective actions. ECM Provider shall respond to all requests from CalOptima for information and documentation to permit ongoing monitoring of ECM.

6.23.14 ECM Data and Reports. Physician shall submit to CalOptima complete, accurate, and timely ECM data and reports in the manner and form acceptable to CalOptima as required by CalOptima Policies or otherwise required by DHCS in order for CalOptima to monitor and meet the following: (i) performance targets; and (ii) its data reporting requirements to DHCS.

6.23.15 ECM Provider's Agent Qualifications - ECM Provider shall verify that the qualifications of all agents (including ECM Provider staff) providing ECM services under this Contract comply with the requirements of this Contract, CalOptima Policies, and DHCS guidance. In addition, for agents that enter into Members' homes or have face-to-face interactions with Members, ECM

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Provider shall also conduct background investigations, including, but not be limited to, County, State and Federal criminal history and abuse registry screening. ECM Provider shall comply with all applicable laws in conducting background investigations and shall exclude unqualified agents from providing services under this Contract.

ARTICLE 7
Obligations of Physician – Reporting

7.1 DATA REPORTING REQUIREMENTS --- Physician shall comply with the data reporting requirements set forth in this Contract, including but not limited to the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and Guidelines referred to as the Timely and Appropriate Submission Requirements. Physician shall provide such additional data and modify the form, content, instructions and timetables for the collection and reporting of data as may be required by CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

7.2 ENCOUNTER REPORTING --- Physician shall submit to CalOptima complete, accurate, reasonable and timely encounter data (a) needed by CalOptima in order for CalOptima to meet its encounter data reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima Policies. Physician shall submit encounter data pursuant to standards defined by CalOptima Policies. Upon first receiving member assignments; or changing management companies, business systems, clearinghouse vendors, and/or contractual model; Physician shall begin encounter data file testing within sixty (60) days and complete testing within ninety (90) days. Physician shall be subject to financial penalties and/or sanctions if CalOptima determines that Physician is reporting to CalOptima less than all professional encounters in the CalOptima required format and timelines. Physician shall have twelve (12) calendar days, upon notification by CalOptima, to correct encounters rejected by CalOptima's regulatory agencies, including the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS). Financial penalties or sanctions shall be assessed upon Physician should CalOptima determine that Physician is not meeting the standards as defined in CalOptima Policies. This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination

7.3 ANNUAL AUDIT AND FINANCIAL REPORTING REQUIREMENTS --- Physician agrees to provide the results of its annual audited financial statements, including "Letters to Management", if requested, for the prior calendar or fiscal year within one hundred twenty (120) calendar days of the completion of that year. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of Physician as related to Members. Physician shall allow representatives of CalOptima, upon written request, to verify the financial report.

7.4 FINANCIAL REPORTING --- If Physician is required to file monthly Financial Statements with the DMHC, Physician shall simultaneously file monthly Financial Statements with DHCS. Physician shall prepare financial information requested in accordance with GAAP. Where Financial Statements and projections are requested, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Health Care Service Plan Act of 1975 rules found under Title 28, CCR, Section 1300.51 et. seq. Information submitted shall be based on current operations. Physician shall submit financial information consistent with filing requirements of the DMHC unless otherwise specified by DHCS.

7.5 PARTICIPATING PROVIDER NETWORK CHANGES --- Physician shall report in compliance with CalOptima Policies, any changes, including but not limited to additions, deletions and location changes of Providers constituting Physician's provider network.

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7.6 PHYSICIAN ORGANIZATION PROFILE --- Physician shall report in compliance with CalOptima Policies, a profile of the Physician's organization, including, but not limited to, Physician's significant administrative and Provider network contractual relationships.

7.7 PARTICIPATING PROVIDER CONTRACTS --- Physician shall provide to CalOptima copies of all contract templates utilized with Participating Providers. Upon modification, change or replacement by Physician, Physician shall provide CalOptima with copies of current contract templates. In addition, upon request from CalOptima or DHCS, Physician shall provide copies of any Subcontract entered into or amended for purposes of fulfilling Physician's obligations under this Contract.

7.8 DISCLOSURE --- Physician and any Subcontractors shall make available to CalOptima, CalOptima's authorized agents, and appropriate representatives of the State and federal government any of Physician's or Subcontractor's financial records related to Physician's capacity to bear the risk of potential financial losses, or the Covered Services performed and amounts paid or payable under this Contract. CalOptima recognizes the proprietary nature of this information and shall make all assurances to maintain its confidentiality in accordance with the California Public Records Act.

7.9 REPORTING UNAUTHORIZED DISCLOSURE OF PRIVATE MEMBER INFORMATION --- In the event that Physician, or any of its officers, employees, agents, or Subcontractors, becomes aware of the unauthorized disclosure of confidential Member information, as described in California Welfare and Institutions Code Section 14100.2, or of "personal information," within the meaning of California Civil Code Section 1798.3, Physician shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this Section, "unauthorized disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not Physician had reasonable control to avoid the disclosure.

7.10 PROVIDER DATA – Physician shall submit to CalOptima complete, accurate, reasonable, and timely provider data and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima Policies.

7.11 REPORTS AND DATA --- In addition to any reporting obligations under this Contract, Physician shall submit reports and data relating to services covered under this Contract as required by CalOptima, in a form and manner specified by CalOptima, including, without limitations, for purposes of complying with requests for reports and data from CalOptima's Regulators to CalOptima.

7.12 CERTIFICATION OF DOCUMENT AND DATA SUBMISSIONS --- All data, information, and documentation provided by Physician to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR § 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Physician's letterhead signed by the Physician's Chief Executive Office or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

ARTICLE 8
Obligations of Physician – Termination

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8.1 OBLIGATION UPON TERMINATION --- Upon termination of this Contract, it is understood and agreed that Physician shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of Physician at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. For Covered Services provided following the month in which Physician received Capitation Payment and termination occurred, Physician shall be paid according to the Medi-Cal Fee Schedule, as defined in CalOptima Policy applicable to such services in effect on the date the services are provided.

8.2 TERMINATION AND TRANSFER OF CARE --- Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's State Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor State contractor, the Physician shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

8.2.1 Physician agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason. Costs of reproduction shall be borne by Physician.

8.3 TERMINATION PLANS --- Physician shall have a plan for the orderly termination of services under this Contract. Physician shall submit a plan regarding coordination of care and payment of claims to CalOptima at least 60 days prior to expiration or termination of this Contract. The termination plan shall require the written approval of CalOptima.

8.4 APPROVAL BY AND NOTICE TO DHCS --- Physician acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of DHCS. CalOptima and Physician shall notify DHCS of amendments to, or termination of, this Contract. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Physician acknowledges and agrees that any amendments or modifications shall be consistent with the requirements relating to submission to DHCS for approval.

8.4.1 Notice to the Department of Managed Health Care. In addition, Physician shall notify the Department of Managed Health Care in the event that this Contract is amended or terminated.

ARTICLE 9
Obligations of CalOptima – Financial

9.1 PAYMENT OF CAPITATION ---

9.1.1 Capitation Payment - Capitation Payment shall be determined by CalOptima by multiplying the Capitation Rate set forth in Attachment E, by the number of Members enrolled with Physician, by age, gender and Aid Code.

9.1.2 Capitation Payment Schedule - CalOptima agrees to pay Capitation Payment to Physician on or about the fifteenth (15^{th}) of the month for enrolled Member. Capitation Rates shall be daily pro-rated basis based upon the Member's effective date of enrollment with Physician.

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9.1.3 Capitation Payment Withhold - CalOptima shall withhold from Physician an amount equal to twenty-five percent (25%) of one (1) month's Capitation Payment (Withhold). CalOptima may adjust Physician's Capitation Payment in accordance with Policy FF.3002.

9.2 CAPITATION RATE ADJUSTMENTS --- The Capitation Rates may be adjusted by CalOptima during the Contract term to reflect implementation of State or federal laws or regulations, changes in the State budget, the State Contract or DHCS policy, and/or changes in Covered Services. Reimbursement is subject to the DHCS providing funds for the purposes of this Contract. Payment adjustments made by DHCS and/or CMS may be reflected in payments to the Physician. If the State has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Physician as soon as practicable. Capitation may also be adjusted in the event of de-delegation of any function delegated under this Contract or Delegation Agreement.

9.3 PAYMENTS FOR PERSONS WITH AIDS --- CalOptima shall pay a supplemental capitation rate, and Physician shall provide services to Members with a confirmed diagnosis of Acquired Immune Deficiency Syndrome (AIDS) in accordance with CalOptima Policy.

9.4 CALOPTIMA RIGHT TO RECOVER.

9.4.1 Overpayments. Physician acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Physician, CalOptima shall have the right to recover such amounts from Physician, in accordance with applicable laws, by recoupment or offset from current or future amounts due from CalOptima to Physician under this Contract.

9.4.2 Health Network Termination. In the event of termination of the Health Network or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of Physician paid by CalOptima against any funds owed to Physician by CalOptima, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

9.4.3 Shared Risk Pool Payments Upon Termination. If this Contract terminated or expires for any reason and Physician Group is responsible for a deficit under any shared risk program under this Contract based on the final shared risk pool report results ("Deficit"), such Deficit shall be due to CalOptima as follows, as allowed by Laws: CalOptima may elect to recoup such Deficit by either (1) offsetting such Deficit amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such Deficits are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

9.4.4 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, CalOptima's Regulators find that Physician (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of FFP, CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (1) offsetting such FFP amounts, upon notice to Physician from any current or future amounts owed by CalOptima to Physician under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (2) sending an invoice to Physician that

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payment for such FFP amounts are due to CalOptima within thirty (30) days of Physician's receipt of the CalOptima invoice.

9.4.5 Dispute Resolution. Physician may use CalOptima's provider dispute resolution procedure, as described under CalOptima's Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts.

9.4.6 Survival. This Section 9.4 shall survive the termination or expiration of the Contract.

9.5 ADDITIONAL PAYMENT --- CalOptima reserves the right to pay Providers or Physician additional sums in any manner that CalOptima deems at its discretion to be beneficial for CalOptima's Members.

9.6 LIMITATION ON CALOPTIMA'S PAYMENT OBLIGATIONS --- Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Physician any Capitation Payment shall be subject to CalOptima's receipt of funding from the State.

9.7 DISPUTES --- Any and all disputes related to payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance by Physician.

9.8 BONE MARROW AND ORGAN TRANSPLANTATION --- In the event that a Member assigned to Physician is actively listed on a DHCS-certified transplant provider list, then the Member will be disenrolled with Physician and enrolled in CalOptima Direct pursuant to CalOptima Policy. For Bone Marrow transplants, Members will be enrolled in CalOptima Direct upon referral to a designated transplant center for a qualifying diagnosis pursuant to CalOptima Policy. Except as provided herein, Physician is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.9 PAYMENT FOR TRANSPLANT EVALUATION --- For Members receiving transplant evaluation services, at a designated DHCS-approved transplant center for the specific transplant type being requested, payment or reimbursement shall be in accordance with CalOptima Policy.

9.10 ADULT MEMBERS DIAGNOSED WITH HEMOPHILIA --- In the event that an adult (age 21+ years) Member assigned to Physician is actively diagnosed as a hemophilia patient, then on the first of the month following diagnosis and notification of CalOptima the adult Member will be disenrolled with Physician and enrolled in CalOptima Direct pursuant to CalOptima Policy. Except as provided herein, Physician is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.11 ADULT MEMBERS DIAGNOSED WITH END STAGE RENAL DISEASE (ESRD) --- In the event that an adult (age 21+ years) Member assigned to Physician is actively diagnosed as an ESRD patient then on first of the month following submission and acceptance of the CMS-2728 – US to the CalOptima Finance Department the adult member will be disenrolled with Physician and enrolled in CalOptima Direct pursuant to CalOptima Policy. Except as provided herein, Physician is responsible for all Covered Services provided to Member until such Member is enrolled as a COD Member.

9.12 FALSE CLAIMS ACT POLICY---Providers receiving more than five (5) million dollars in a year are required to have a policy to educate employees about the False Claims Act and other State and Federal laws.

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ARTICLE 10
Obligations of CalOptima – Administrative

10.1 FINANCIAL SECURITY REQUIREMENTS --- CalOptima shall designate amounts of funds Physician shall establish and maintain as financial security reserves. CalOptima shall identify in CalOptima Policies those financial instruments that shall be acceptable means for purposes of complying with financial security requirements. On a quarterly basis, CalOptima will calculate the minimum required financial security reserves and communicate in writing to the Physician any material deficits.

10.2 COMPREHENSIVE PHYSICIAN AUDIT --- CalOptima shall conduct and Physician shall agree to a full comprehensive compliance audit to be conducted at Physician administrative offices and/or Facilities and/or via desktop/virtual review annually, or as deemed necessary, by CalOptima. CalOptima shall submit results of the Physician audit in writing to Physician. Physician may rebut and dispute audit findings pursuant to CalOptima Policies. Physician is responsible for implementing the corrective measures (if any). CalOptima retains the right to publish data obtained from the audit. Physician acknowledges and agrees that CalOptima may publish the audit data to Members and/or the general public without further notice to or consent from Physician.

10.3 ENCOUNTER DATA AUDIT --- On an annual basis, CalOptima shall conduct an Encounter audit. The audit shall consist of CalOptima requesting a percentage of each Physician's Member Medical Records. These records shall be reviewed for services provided. These services shall then be compared to reported Encounters to determine if the Physician accurately reported all Encounters.

10.4 INTENTIONALLY LEFT BLANK

10.5 INTENTIONALLY LEFT BLANK

10.6 POLICIES AND PROCEDURES AVAILABILITY--- CalOptima shall provide or make available for Physician copies of current CalOptima Policies relevant to the provisions of this Contract. Copies of current CalOptima Policies relevant to the provisions of this Contract may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.7 MOU AVAILABILITY--- CalOptima shall provide or make available for Physician copies of current MOUs entered into by CalOptima that are binding on Physician within seven (7) working days of execution. Copies of current MOUs entered into by CalOptima that are binding on Physician may be provided by the distribution of hard-copy documents, electronic files and/or documents and/or on the CalOptima website.

10.8 INTERPRETATION OF MOUs --- CalOptima shall provide or make available for Physician interpretation of MOUs entered into by CalOptima that are binding on Physician. Interpretation of MOUs will identify duties, obligation and responsibilities of Physician.

10.9 RELEASE OF PERFORMANCE INFORMATION AND DATA --- Physician acknowledges and agrees that CalOptima may release to Providers, Members and others without further notice to Physician, information and data relating to the performance of Physician that CalOptima determines among other things would contribute to Providers', Members' and others' evaluation of options and alternatives and/or making informed selections and decisions regarding health care and the provision of Covered Services.

10.10 PROVIDER COMPLAINT SYSTEM --- CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider and Physician shall have access to this system for any issues arising under this Contract, as provided in CalOptima

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Policy related to CalOptima Medi-Cal Program. Physician complaints, grievances, appeals, or other disputes regarding any issues arising under the Contract shall be resolved through this system.

10.11 RISK ARRANGEMENTS DISCLOSURE --- CalOptima shall provide timely notice regarding those items provided for under Subsections (a)(1) through (a)(3) of Section 1300.75.4.1 of Title 28 of the California Code of Regulations.

10.12 DISCLOSURES ---

10.12.1 ANNUAL FINANCIAL RISK DISCLOSURE – On the Contract anniversary date each year, CalOptima shall disclose to Physician the financial risk assumed under the Contract by providing to Physician the following information for each and every type of Risk Arrangement (including, but not limited to, Medicare Advantage, Medi-Cal, commercial, point of service, small group, and individual plans) covered under this Contract:

10.12.1.1 A division of responsibility for medical expenses (physician, institutional, ancillary, and pharmacy) which will be allocated to Physician, a hospital(s) or CalOptima under the Risk Arrangement.

10.12.1.2 Expected/projected utilization rates and unit costs for each major expense service group (inpatient, outpatient, PCP, specialist, pharmacy, injectables, home health, durable medical equipment, ambulance and other), as well as the source of the data and the actuarial methods employed in determining the utilization rates and unit costs by each and every type of Risk Arrangement.

10.12.1.3 All factors used to adjust payments or risk-sharing targets, including, but not limited to, the following: age, sex, localized geographic area, family size, experience rated, and benefit plan design, including copayment/deductible levels.

10.12.1.4 The amount of payment for each and every service to be provided under the Contract, including any fee schedules or other factors or units used in determining the fees for each and every service. To the extent that reimbursement is made pursuant to a specified fee schedule, the fee schedule shall be incorporated into the Contract by reference, and shall specify Medicare resource-based relative value scale ("RBRVS") year if RBRVS is the methodology for the fee schedule development. For any proprietary fee schedule, the Contract shall include sufficient detail that payment amounts related to that fee schedule can be accurately predicted.

10.12.2 ANNUAL DISCLOSURE OF CAPITATION PAYMENTS – On the Contract anniversary date each year, CalOptima shall disclose to Physician the amount of capitation payments to be paid per member per month.

10.12.3 CAPITATION DEDUCTION DETAIL – CalOptima shall provide to Physician sufficient details to allow Physician to verify the accuracy and appropriateness of any deductions from capitation payments made by CalOptima including, but not limited to, member name, member number, member date-of-birth, billing provider name, date-of-service, procedure/service codes billed, and amount paid.

ARTICLE 11
Obligations of CalOptima – Termination

11.1 MEMBER AND PROVIDER COMMUNICATION --- CalOptima shall approve all Physician, Member and provider communications relating to termination of this Contract, prior to distribution.

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11.2 APPROVAL OF PHYSICIAN TERMINATION PLANS --- CalOptima shall review and approve Physician termination plans at intervals and frequencies established by CalOptima Policies.

11.3 RELEASE OF WITHHOLD --- CalOptima shall release Physician's capitation withhold to Physician upon the latter of nine (9) months following the termination, or upon CalOptima's validation of completion by Physician of all post-termination requirements contained in this Contract and CalOptima Policy. In the event that all post-termination requirements have not been met within nine (9) months following termination, CalOptima may, at its sole discretion, apply Physician's capitation withhold funds to satisfy unmet post-termination requirements.

11.4 RELEASE OF FINANCIAL SECURITY REQUIREMENT DEPOSITS --- CalOptima shall release to Physician financial security requirement deposits no less than six (6) months following the termination of this Contract unless termination is the result of Physician insolvency. CalOptima shall release to Physician financial security requirement deposits no less than twelve (12) months following the termination of this Contract if termination is the result of Physician insolvency.

ARTICLE 12
Health Care Delivery System

12.1 OUT-OF-COUNTY SERVICES --- Physician may contract with out-of-county facilities for Covered Services for CalOptima Members provided that Physician ensures that it coordinates the Member's care and complies with all access, quality and other CalOptima requirements.

ARTICLE 13
Termination and Modification of Contract Terms

13.1 SANCTIONS AND TERMINATIONS FOR CAUSE --- If Physician fails to fulfill any of its duties and obligations under this Contract, including but not limited to: (i) committing acts to discriminate among Members on the basis of their health status or requirements for health care services; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the Physician by Members whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under the provisions of this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's Compliance Program, including Participation Status requirements; (vi) failing to meet financial security requirements; (vii) committing fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; (viii) failure to ensure that all Minimum Standards are met; (ix) failure to enforce claims payment prohibitions on providers who are denied the right to submit claims and/or receive reimbursement for services furnished to CalOptima Members; (x) not having the required amounts and types of financial reserves; (xi) failure of Participating Providers to comply with the prior authorization process and other pharmacy requirements as determined by CalOptima; (xii) failure to meet Medical Loss Ratio requirements; (xiii) failure to meet minimum enrollment requirements; (xiv) failure to meet quality and/or performance requirements; (xv) failure to comply with organization structure requirements as set forth in Section 3.10 of this Contract; (xv) failure to submit Encounter Data pursuant to this Contract and CalOptima Policy; (xvi) a failure to perform an obligation or duty under the Prior Contract and/or failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, and (xvii) a violation of the Department of Managed Health Care's Risk Bearing Organization regulations, including reporting, auditing or Corrective Action Plan compliance violations, CalOptima may take any of the actions described below:

13.1.1 Corrective Action Plan (CAP) - CalOptima may require a CAP in the event that any report, audit, survey, site review or investigation indicates that the Physician or any Subcontractor(s) is not in compliance with any provision of this Contract or other Medi-Cal program requirement. A CAP shall be required if CalOptima receives a substantiated

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complaint or grievance related to the standard of care provided by the Physician or any Subcontractors. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within fourteen (14) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP.

13.1.2 General Sanctions - Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the Physician is not in compliance with the provisions of this Contract, CalOptima Policies and minimum performance requirements as established by CalOptima.

13.1.2.1 All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period shall result in CalOptima deducting the penalty plus the administrative fee from the Physician's Capitation Payment.

13.1.2.2 Physician may appeal CalOptima's decision to impose a sanction, by filing a complaint pursuant to CalOptima Policies. Physician shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policy, before commencing a civil action.

13.1.3 Termination for Cause –Notwithstanding, and in addition to, any other provisions of this Contract, either party may terminate this Contract for cause effective upon thirty (30) calendar days' written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 13.1. Physician may appeal CalOptima's decision to terminate the Contract for cause by filing a complaint pursuant to CalOptima Policies. Physician shall exhaust all administrative remedies before commencing any civil action.

13.1.3.1 In the event of a "Termination for Cause" as provided by this Section, CalOptima may procure, upon such terms and in such manner as it shall deem appropriate, supplies or services similar to those terminated.

13.1.3.2 CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

13.2 TERMINATION FOR INSUFFICIENT CALOPTIMA MEDI-CAL ENROLLMENT --- CalOptima reserves the right in accordance with CalOptima Policies to terminate the Physician in the event that Physician's membership falls below five-thousand (5,000) total members at any time based upon a three (3) month rolling average of Physician's membership.

13.3 TERMINATION FOR FAILURE TO MEET QUALITY REQUIREMENTS --- CalOptima may terminate this Contract immediately should Physician fail to comply with or fail to be in compliance with quality requirements as may be established and modified from time to time by CalOptima and/or DHCS.

13.4 TERMINATION FOR FAILURE TO MEET MEDICAL LOSS RATIO REQUIREMENTS --- CalOptima may terminate this Contract with thirty (30) days written notice should Physician fail to comply with or be in compliance with medical loss ratio requirements established in this Contract and CalOptima Policies.

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13.5 TERMINATION OF STATE CONTRACT --- CalOptima may terminate this Contract immediately upon termination of the State Contract.

13.6 TERMINATION UPON LOSS OF WAIVER --- This Contract shall terminate immediately upon written notice from CalOptima to Physician that HHS has withdrawn its approval of the waiver granted under Section 1915(b) of the Social Security Act for COHS.

13.7 TERMINATION FOR PHYSICIAN ORGANIZATION AND OPERATIONS STRUCTURE --- CalOptima may terminate this Contract immediately should Physician fail to comply with requirements for Physician's organization and operation structure established in this Contract and CalOptima Policies.

13.8 Not Applicable to this Contract.

13.9 TERMINATION FOR CONVENIENCE --- Either party may terminate the Contract for convenience, without cause, by giving one hundred eighty (180) calendar days advance written notice to the other party prior to the effective date of such termination.

13.10 TERMINATION FOR PHYSICIAN INSOLVENCY --- If Physician becomes insolvent, Physician shall immediately advise CalOptima, and CalOptima shall have the right to terminate the Contract upon the same terms and conditions as a "Termination for Cause", set forth in Section 13.1. In the event of the filing of a petition for bankruptcy by or against Physician or a principal Subcontractor, Physician shall assure that all Physician's functions and duties related to the Subcontract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to Physician until Physician fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any and all withheld amounts as necessary to ensure that all Physician obligations have been met.

13.11 TERMINATION BY PHYSICIAN FOR CAUSE ---Either party may terminate this Contract for cause upon thirty (30) calendar days' prior written notice to the other party. Cause shall mean either parties failure to fulfill any of its duties and obligations under this Contract for a period of thirty (30) calendar days following the breaching party's receipt of the notice detailing the cause from the non-breaching party. Termination shall be effective thirty (30) calendar days notice period and subject to DHCS approval. In the event of termination due to breach, Parties shall comply with Section 8.3 as part of any such for cause termination.

13.12 MODIFICATIONS OR TERMINATIONS TO COMPLY WITH LAW--- CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by the State Contract, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima shall notify Physician in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and Physician shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

13.13 PERFORMANCE MEASURE AND PAYMENTS TO PHYSICIAN --- CalOptima may establish key performance measures of Physician to set minimum contract performance thresholds and/or pay financial incentives to Health Networks and Physician groups. CalOptima may take the following actions, at it sole discretion, based upon the results of such performance measures: require corrective action plans, impose sanctions against Physician, terminate this Contract, and establish Capitation Rates and other payments to Physician.

13.13.1 Physician will distribute directly to Participating Providers at minimum of eighty-five percent (85%) of any quality pay for value incentive payment(s) that CalOptima may

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makes to Physician directly to Participating Providers, beginning with Measurement Year 2024.

13.14 PROHIBITION ON USE OF CERTAIN PROVIDERS --- Physician agrees as follows:

13.14.1 CalOptima reserves the right to require Physician, upon notification from CalOptima, to prohibit any Subcontractor and/or Provider from providing services, whether Covered Services or otherwise, to Members when CalOptima deems such prohibition to be in the best interests of the Members. Imposition of the foregoing prohibition shall not terminate this Contract.

13.14.2 CalOptima requires that Physician Participating Providers and/or Subcontractors who do not meet all of Minimum Standards as described in applicable CalOptima Policies, be prohibited from furnishing items or services and/or submitting claims and/or receiving reimbursement for items and/or services furnished to Members. CalOptima may also require that Physician terminate a Participating Provider's right to furnish items or services and/or submit claims and/or receive reimbursement for items and/or services furnished to Members based on the denial of such Participating Provider's right to participate in CalOptima Direct whether based on a credentialing, recredentialing and/or peer review decision.

13.15 NOTICE OF NON-RENEWAL --- In order for CalOptima to facilitate Member transition to other Health Networks or Physician groups, Physician shall provide CalOptima with an advance notice of non-renewal of the Contract in accordance with Section 13.9 prior to the end date of the Contract term in the event Physician elects not to participate in any extension period or new contract term.

13.16 Not Applicable to this Contract.

13.17 EXTENSION, RENEWAL, OR MODIFICATION – Any extension, renewal, or modification of this Contract shall be made by written amendment signed by the parties, upon formal approval by CalOptima Board of Directors, and in accordance with Section 8.4 of this Contract.

ARTICLE 14
Miscellaneous

14.1 INTERPRETATION OF CONTRACT LANGUAGE --- DHCS has the right to final interpretation of the Contract language, and the parties agree that the Contract will be interpreted to comply with applicable laws and DHCS and Medicaid standards.

14.2 INDEPENDENT CAPACITY OF PHYSICIAN --- CalOptima and Physician agree that Physician and any agents or employees of Physician, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima.

14.3 NO WAIVER OF IMMUNITY OR PRIVILEGE --- Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

14.4 OMISSIONS --- In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

14.5 GOVERNING LAW AND VENUE--- This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the State Contract between

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CalOptima and DHCS. Physician shall be required to bring all legal proceedings against CalOptima in State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceeding shall be brought in the Central District Court of California.

14.6 WAIVER --- No delay or failure by either party hereto to exercise any right or power accruing upon non-compliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

14.7 SEVERABILITY --- If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to Members and if the remainder of this Contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

14.8 FORCE MAJEURE --- Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes.

14.9 HEADINGS --- The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

14.10 ASSIGNMENT OR DELEGATION ---Physician agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Physician or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Physician or Subcontractor; (iii) the merger, reorganization, or consolidation of Physician or Subcontractor with another entity with respect to which Physician or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Physician or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Physician or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

14.11 NO LIABILITY OF COUNTY OF ORANGE --- As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Physician hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefore.

14.12 CONFIDENTIALITY OF RECORDS --- As a condition of access to any record utilized or maintained by DHCS, the Declaration of Confidentiality, a copy of which is incorporated into this Contract as Attachment D, shall be signed and filed with DHCS for every individual prior to that individual being allowed access to computer files or any other data or files which are made confidential by statute, including identification of individual Members.

14.13 DEBARMENT CERTIFICATION --- By signing this Contract, the Physician agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

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14.13.1 By signing this Contract, the Physician certifies to the best of its knowledge and belief, that it and its principals:

14.13.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

14.13.1.2 Have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

14.13.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in this Section herein; and

14.13.1.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default.

14.13.1.5 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

14.13.1.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

14.13.2 If the Physician is unable to certify to any of the statements in this certification, the Physician shall submit an explanation to CalOptima.

14.13.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

14.13.4 If the Physician knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

14.14 SMOKE FREE WORKPLACE --- Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance

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order on the responsible party. By signing this Contract, Physician certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Physician further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

14.15 AIR OR WATER POLLUTION REQUIREMENTS--Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Physician agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

14.16 LOBBYING RESTRICTIONS AND DISCLOSURE CERTIFICATION—

14.16.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

14.16.2 Certification and Disclosure Requirements

14.16.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment F, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Section 14.16.2.2.

14.16.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment F, entitled "Standard Form-LLL Disclosure of Lobbying Activities") if such recipient has made or has agreed to make any payment using non-appropriated funds to include profits from any covered federal action in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Section 14.16 if paid for with appropriated funds.

14.16.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under this Section herein. An event that materially affects the accuracy of the information reported includes:

14.16.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

14.16.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

14.16.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

14.16.2.4 Each person (or recipient) who requests or receives from a person referred to in this Section of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

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14.16.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in this Section of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

14.16.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14.17 NOTICES --- All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the party to whom notice is given, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid, addressed to the party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima
Attention: Director of Contracting
505 City Parkway West
Orange, California 92868

To: Physician
Providence Medical Foundation
Attention: Vice President, Payer Contracting
15480 Laguna Canyon Road
Irvine, CA 92618

14.18 GOVERNMENT CLAIMS ACT --- Physician shall ensure that Physician and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code sections 900 et seq.), including, but not limited to Government Code section 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

14.19 DISPUTE RESOLUTION.

14.19.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, or if either party has a dispute it seeks to address informally, the parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The parties shall meet and confer within thirty (30) days of a written request submitted by either party in an effort to settle any dispute. At each meet-and-confer meeting, each party shall be represented by persons with final authority to settle the dispute. If either party fails to meet within the thirty (30)-day period, that party shall be deemed to have waived the meet-and-confer requirement, and at the other party's option, the dispute may proceed immediately to arbitration under Section 14.19.2.

14.19.2 Arbitration. If the parties are unable to resolve any dispute arising out of or relating to this Contract under Section 14.19.1, either party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The parties may agree in writing prior to commencing

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the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the parties, two from each side; provided, however, that nothing stated in this section shall prevent a party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The parties shall share the costs of arbitration equally, and each party shall bear its own attorneys' fees and costs.

14.19.3 Exclusive Remedy. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 14.19.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes.

14.19.4 Waiver. By agreeing to binding arbitration as set forth in Section 14.19.2, the parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

14.20 Catholic Directives. Nothing in this Contract shall require Physician to provide any Excluded Services under this Contract which would violate Physician Ethical and Religious Directives.

ARTICLE 15
Signatures

15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS CONTRACT SHALL BE FROM NOVEMBER 1, 2025, THROUGH JUNE 30, 2027 AND FIVE (5) ADDITIONAL ONE-YEAR AUTOMATIC EXTENSIONS (JULY 1 THROUGH JUNE 30) EXCEPT AS DIRECTED OTHERWISE BY THE BOARD.

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IN WITNESS WHEREOF, the **CalOptima** and **Providence Medical Foundation** have executed this Contract:

FOR PHYSICIAN:	FOR CALOPTIMA:
Signature	Signature
Nate Husmann	
Print Name	Print Name
Chief Contracting Officer	
Title	Title
Date	Date

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ATTACHMENT A
CalOptima Medi-Cal Division of Financial Responsibility
Effective: November 1, 2025

Note: The purpose of the Division of Financial Responsibility is to identify how CalOptima allocated to the Physician and Hospital components of the medical costs associated with the provision of Covered Services. That is, the capitation and Hospital Budget rates in this Contract are based upon the Physician and Hospital Budget being financially responsible for the provision of Covered Services as indicated in this Division of Financial Responsibility. The Division of Financial Responsibility should not be used in place of the CalOptima EOC/EOB for making coverage determinations.

	Responsible Party		
	Physician	**Hospital**	**Other**
Acupuncture	**X**		
Allergy Testing & Treatment			
Testing	**X**		
Serum	**X**		
Immunotherapy injections	**X**		
Ambulance	***- See Transportation -***		
Amniocentesis	**X**		
Anesthesia - for medical diagnosis (Includes medical, dental, mental health, etc.…)			
Professional component	**X**		
Facility component		**X**	
Birth Control	***- See Family Planning -***		
Blood and Blood Products			
From blood bank		**X**	
Transfusions, blood and blood components		**X**	
Autologous Transfusion (including collection of)		**X**	
Outpatient Transfusion, Blood and Blood Components		**X**	
Breast Implant (post-mastectomy) or Removal (medically necessary only)			
Professional component	**X**		
Facility component		**X**	
Breast Reconstructive Surgery (after cancer)			
Professional component	**X**		
Facility component		**X**	
CBAS			***CalOptima (Claims)***
CHDP	***- See Pediatric Preventive Services -***		
Chemotherapy			
Professional Component	**X**		
Outpatient Facility Component		**X**	
Medication	***- See Medication -***		

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	Physician		Hospital		Other
Chiropractic Services	**X**				
Cosmetic Surgery (Medically necessary)					
Professional component	**X**				
Facility component (licensed surgical center or acute facility only)			**X**		
Dental Services					
General dental services - Including teeth					***Denti-Cal***
Oral Maxillofacial Surgery (Repair of accident/ injury; medically necessary - Excluding teeth)					
Professional component	**X**				
Facility component			**X**		
Anesthesia Services (related to dental services)					
Professional component (Other than provided by Dentist)	**X**				
Professional component (Provided by Dentist)					***Denti-Cal***
Facility component			**X**		
Detoxification - Medical (inpatient acute medical facility only)					
Professional component	**X**				
Facility component			**X**		
Diagnostic Services, (Outpatient) Including Radiology and procedures billed with endoscopy or colonoscopy diagnostic codes (includes imaging, GI lab, pathology lab, etc. and related facility room charges and dyes, drugs and solutions required for the service)					
Professional component	**X**				
Facility component	**X**				
Diagnostic Services (Inpatient), Including Radiology					
Professional component	**X**				
Facility component			**X**		
Dialysis					
Professional component	**X**				
Facility component			**X**		
Durable Medical Equipment (DME) (including insulin pumps and Medi-Cal covered Continuous Glucose Monitors)					
Inpatient			**X**		
Outpatient (including supplies necessary for use of the equipment)	**X**				
Custom Wheelchair Assessment (excluding those conducted through MTP)	**X**				
Custom Wheelchair Assessments through MTP					***OC HCS/State***
Emergency Room (POS 23) Minor DME (cane, crutches) and non-custom Splints dispensed at time of ER visit and billed by other than hospital			**X**		

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	Physician		Hospital		Other
Emergency Services (hospital based)					
Professional Component, i.e. evaluation, treatment, and management services, and professional component of diagnostic testing including: radiology, pathology, clinical laboratory services, cardiology, and other similar services.	**X**				
Facility component, i.e. room use, surgical and medical supplies, and the technical component of diagnostic testing.			**X**		
Mental Health Post Triage / Emergency Stabilization Treatment - admitted to inpatient psychiatric facility					***OC HCA / State***
Enteral and Parenteral Nutrients, Pumps and Supplies	***- See Nutritional Products-***				
EPSDT Services[2]					
Acupuncture	**X**				
Autism Screening	**X**				
Audiology	**X**				
Chiropractic	**X**				
Cochlear Implant	**X**				
Dental Services					***State***
EPSDT Case Management	**X**				
Hearing Aid Batteries	**X**				
In-Home Private Duty Nursing (PDN)					***CalOptima (Claims)***
Mental Health - Specialty Outpatient					***OC HCA / State***
Medical Nutrition Services	**X**				
Occupational Therapy[1]	**X**				
Orthodontic Services					***Denti-Cal***
Pediatric Day Health Care Service (CCS)					***State***
Speech Therapy	**X**				
Family Planning (all provider types)					
Professional component					***CalOptima (Claims)***
Surgically implanted sterilization devices					***CalOptima (Claims)***
IUDs (with or without medication)					***CalOptima (Claims)***
Contraceptive items/supplies billed by a non-pharmacy provider					***CalOptima (Claims)***
Condoms, diaphragms and cervical caps when billed by a Pharmacy					***DHCS PBM***
Medications	***- See Medications -***				
Genetic Disease Screening					
Prenatal Triple Marker Screening					***DHCS Genetic Disease Branch***

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	Physician		Hospital		Other
Follow-up services for positive prenatal screening					***DHCS Genetic Disease Branch***
Newborn screening panel			**X**		
Other Genetic Testing/Counseling	**X**				
Hearing Aids	**X**				
Hearing Screening	**X**				
Home Health Care					
Care for medical conditions			**X**		
Care for psychiatric conditions					***OC HCA / State***
Injectable medications	***-See Medication -***				
Home infusion	***-See Medication -***				
Home Health and Home Infusion Pumps & Supplies (including Total Parenteral Nutrition Supplies)			**X**		
Hospice Services (ALL levels of services at any facility/location/setting)			**X**		
Hospitalization - Acute Inpatient Facility and Short Stay Sub-acute and Skilled Nursing Services Provided in Lieu of Acute Inpatient Hospitalization (Including ancillary services, supplies, and testing)					
Acute Medical			**X**		
Psychiatric					***OC HCA / State***
Hyperbaric Oxygen Therapy			**X**		
Immunizations	***- See Preventive Services -***				
Laboratory Services					
Inpatient - Medical (technical component)			**X**		
Inpatient – Psychiatric					***OC HCA / State***
Inpatient – Medical (professional component)	**X**				
Outpatient free-standing Lab or facility setting (professional and technical components)	**X**				
Emergency Room	***- See Emergency Services -***				
Long-Term Care Services, including Custodial (Sub-acute, NF Level A, NF Level B, ICF/DD, ICF/DD-N, ICF/DD-H) for Members who are residing in the LTC facilities					
Room and Board (facility daily rate)					***CalOptima (Claims)***
Professional services	**X**				
Ancillary services	**X**				
Mammography and Screening	**X**				
Medical/Surgical Supplies and Dressings					
Inpatient			**X**		

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	Physician		Hospital		Other
Outpatient Medical/Surgical Supplies and Dressings					
Disposable Medical Supplies (including Medi-Cal Categories: Enteral, Tracheostomy, Ostomy, Urological, Wound Care, Infusion Tubing) and Supplies billed by a non-Pharmacy Provider	**X**				
Other Disposable Medical Supplies when billed by a Pharmacy					***DHCS PBM***
Medication					
Inpatient					
Acute Medical			**X**		
Acute Psychiatric					***OC HCA/State***
Long Term Care Facility					***DHCS PBM***
Outpatient Medication billed by a Pharmacy					***DHCS PBM***
Outpatient Medication billed by non-Pharmacy Providers					***CalOptima (Claims)***
Mental Health					
Behavioral Health Professional Services					
Outpatient Office-Mild to Mod, Psychiatric Consult in Med/Surg, Long Term Care, and ER-no psych inpatient admission, Psychological Testing					***CalOptima (Claims)***
Outpatient Office-Severe Persistent Mental Illness, Inpatient Psychiatric Unit					***OC HCA/State***
Electroconvulsive Treatment (psychiatrist)					***OC HCA/State***
Applied Behavior Analysis (ABA)					***CalOptima (Claims)***
Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP)			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Behavioral Health Facility					
Acute Care Facility ER not resulting in psych admission			**X**		
County Evaluation and Treatment Services/County Crisis Stabilization Unit, Psych Inpatient Unit					***OC HCA/State***
Partial Hospitalization Program or Intensive Outpatient PHP, IOP			**-In OC-Service is NOT a Medi-Cal Benefit-**		
Electroconvulsive Treatment Outpatient			**X**		
Substance Use Disorder (SUD) Professional					
Outpatient-Office-Mild to Mod, Medication Assisted Treatment (MAT)-Psychiatrist					***CalOptima (Claims)***

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	Physician		Hospital		Other
Outpatient-DMC Provider, Intensive Outpatient-DMC Provider					***Drug Medi-Cal***
ER-SUD Consultation					***CalOptima (Claims)***
Inpatient-MD, Detox Outpatient-MD, Intensive Outpatient at Hosp-MD, MAT-PCP, Alcohol Misuse Screening and Counseling-PCP	**X**				
Substance Use Disorder (SUD) Facility					
Acute Care Facility (includes members with substance abuse diagnosis/symptoms), Acute Care Facility (Detox Acute), Acute Care Facility (Rehab)			**X**		
Acute Care Facility (Voluntary Inpatient Detox)					***DHCS***
Residential (Detox/Rehab)					***Drug Medi-Cal***
Neuropsych Testing	**X**				
Nuclear Medicine Diagnostic and Treatment/Therapy					
Professional Component	**X**				
Facility Technical Component (hospital & free-standing centers)			**X**		
Nutritional Dietetic Counseling / Medical Nutrition Therapy/Health Education	**X**				
Nutritional Products					
Total Parenteral Nutrition (TPN) when provided by Pharmacy					***DHCS PBM***
Total Parenteral Nutrition (TPN) when provided by non-Pharmacy provider					***CalOptima (Claims)***
Total Parenteral Nutrition (TPN) supplies and pumps			**X**		
Enteral Nutrition products included in the DHCS Enteral Nutrition product list					***DHCS PBM***
Enteral Nutrition Supplies and Pumps	**X**				
Other Nutrition Products when not covered by DHCS PBM	**X**				
Obstetrical Care					
Outpatient diagnostic services	**X**				
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Emergent diagnostic (OB Unit)			**X**		
Ultrasound	**X**				
Perinatal care (Includes 60 days postpartum)	**X**				
Perinatal Support Services					***CalOptima (Capped & Claims)***
Fetal Monitoring					
Professional component	**X**				
Facility component			**X**		
Occupational Therapy	***- See Rehabilitation -***				
Orthotics	**X**				
Outpatient Diagnostic Services	**-See Diagnostic Services (Outpatient)-**				

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	Physician		Hospital		Other
Outpatient Surgery, including procedures billed with endoscopy or colonoscopy surgical codes, cardiac or other catheterization procedures (includes ancillary services, supplies and diagnostic testing)					
Professional component	**X**				
Facility component			**X**		
Out of Area Services	**Follows appropriate DOFR Section**				
Pharmacy	***- See Medication -***				
Physical Therapy	***- See Rehabilitation -***				
Physician Services					
Inpatient	**X**				
Outpatient	**X**				
Podiatry Services	**X**				
Pediatric Preventive Services (includes CHDP)					
Well Child Visits	**X**				
Immunizations (Ages 0-18 years)					
Vaccine					***VFC (Vaccines for Children Program)***
Administration fee	**X**				
Immunizations (19 and over)					
Vaccine billed by a non-Pharmacy provider (inclusive of Medi-Cal administration fee)	**X**				
Vaccine billed by a Pharmacy					***DHCS PBM***
Adult Periodic Health Exams	**X**				
Prosthetic Devices					
Surgical implantation	**X**				
Surgically implanted device/prosthetic			**X**		
Non-implanted device/prosthetic	**X**				
Radiation Therapy					
Professional component	**X**				
Facility component			**X**		
Radiology Services	***- See Diagnostic Services -***				
Rehabilitation - Physical, Occupational, & Speech Therapy					
Inpatient professional component	**X**				
Inpatient facility component			**X**		
Outpatient professional component[1]	**X**				
Outpatient facility component[1]	**X**				
Long Term Care Facility	**X**				
Skilled Nursing Facility					
Custodial – Long Term Care	***- See Long Term Care Services -***				
Short stay	***- See Hospitalization -***				
Speech Therapy	***- See Rehabilitation -***				
Termination of Pregnancy					
Professional component (including Mifiprestone/RU-486)					***CalOptima (Claims)***
Facility component					***CalOptima (Claims)***
Transgender Services					

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	Physician		Hospital		Other
Professional component					***CalOptima[3]***
Facility component					***CalOptima[4]***
Transplants - Including Procurement					
BMT & Solid Organ Transplants Evaluations (Per CalOptima Policy)					***CalOptima (Claims)***
Organ Transplants (Per CalOptima Policy)					***CalOptima (Claims)***
All Other Transplants (e.g. bone, cornea, skin)					
Professional Component	**X**				
Facility Component			**X**		
Transportation (includes ambulance)					
Emergency			**X**		
Non-Emergency Medical Transportation (NEMT)			**X**		
Non-Medical Transportation (NMT)					***CalOptima (Claims)***
Tuberculosis (TB) Treatment					
Direct Observed Therapy (DOT) TB Treatment (provided by OC HCA only)					***OC HCA Responsibility***
Non-DOT TB Treatment provided by OC HCA					***CalOptima (Claims)***
Non-DOT TB Treatment provided by non-OC HCA Provider	**X**				
Vision Care					
Routine adult and child eye refraction examination					***CalOptima (TPA)***
Contact lenses					***CalOptima (TPA)***
Lenses and frames					***CalOptima (TPA)***
Argon laser trabeculoplasty	**X**				
Intraocular lens - surgically implanted			**X**		
Ophthalmological services	**X**				
Prosthetic eye (Professional services only)	**X**				
Whole Child Model-Previously California Children's Services					
Professional component including all Special Care Center services billable on a professional claim	**X**				
Facility component including all Special Care Center services billable on a facility claim			**X**		
Maintenance and Transportation					***CalOptima (Claims)***
Medical Therapy Program					***OC HCA / State***

If there is a reasonable dispute as to which Party is the ultimate payor for a Covered Service, the Parties shall meet and confer in accordance with Section 14.19.1 of this Contract.

[1] *Services are the responsibility of MTP if provided under the MTP program.*

[2] *Services listed under the EPSDT are considered to be a guideline and not a benefit, financial responsibility is listed in the appropriate categories within DOFR for EPSDT services.*

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[3] *Services identified as Transgender, at the discretion of Physician, that are in conflict with the Ethical and Religious Directives can be forwarded to CalOptima for payment and capitation deduction.*
[4] *Services identified as Transgender, at the discretion of Physician, that are in conflict with the Ethical and Religious Directives will be fully deducted against the shared-risk budget, i.e. no gain-sharing will be permitted.*

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ATTACHMENT B
DISCLOSURE FORM

Pursuant to DHCS APL 23-006, Medi-Cal managed care plans like CalOptima must comply with the ownership and control disclosure requirements as set forth in 42 CFR § 455.104 by collecting information on whether their Subcontractors are persons with ownership or control interest or managing employees. Provider shall complete and return this form to CalOptima in accordance with CalOptima instructions prior to the Effective Date and submit updates to this form to CalOptima within thirty (30) days of any change to this form.

The undersigned hereby certifies that the following information regarding **Providence Medical Foundation** (the "**Provider**") is true and correct as of the date set forth below:

Form of Provider (Corporation, Partnership, Sole Proprietorship, Individual, etc.):_____

_____

Officer(s)/Director(s)/General Partner(s)/Managing Employees: _____

_____

Co-Owner(s): _____

_____

Individuals with an Ownership or Control Interest owning more than five percent (5%) of the Provider's stock: Please list all individuals with an ownership or control interest. Include each person's name, address, date of birth (DOB), and Social Security Number (SSN). Indicate the title (*e.g.* chief executive officer, owner) and if an owner, the percentage of ownership.

Name	Title	% Ownership	DOB	SSN

Corporation with and Ownership or Controlling Interest holding more than five percent (5%) of the Provider's debt: Please list all corporations with an ownership or control interest in the applicant. Include the Tax Identification Number (TIN), the percent of ownership in the applicant, the P.O. Box address(es). Attach additional pages as needed.

Name of Corporation	TIN	% Ownership	P.O. Box

[*signature page follows*]

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Dated: _____ Signature: _____

Name: _____
(Please type or print)

Title: _____

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ATTACHMENT C

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ATTACHMENT D

LETTER OF AUTHORIZATION PROCEDURES RELEASE/ACCESS OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES COMPUTER FILES FOR THE MEDI-CAL PROGRAM

DECLARATION OF CONFIDENTIALITY

As a condition of obtaining access to information concerning procedures or other data records utilized/ maintained by the Department of Health Care Services (DHCS) and CalOptima, I, _____, agree not to divulge any information obtained in the course of my assignment to unauthorized persons, and I agree not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

Access to such data shall be limited to _____, _____ fiscal agent, State and federal personnel who require the information in the performance of their duties and to such others as may be authorized by CalOptima.

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

_____
Signed

_____
Date

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ATTACHMENT E

CAPITATION RATES

Effective November 1, 2025

Payments by CalOptima to Health Network for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
Child/Adult	00-00 year, Both	[redacted]	[redacted]	[redacted]
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40-64 years, Both			
	65+ years, Both			
Medi-Cal Expansion	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40- 64 years, Both			
	65+ years, Both			
SPD	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			
	40- 64 years, Both			
	65+ years, Both			
WCM	00-00 year, Both			
	01-14 years, Both			
	15-18 years, Female			
	15-18 years, Male			
	19-39 years, Female			
	19-39 years, Male			

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Aid Code Category	Age & Gender Category	Base Hospital	Base Physician	Total Cap Rate
ESRD	All ages, Both	[redacted]	[redacted]	[redacted]
AIDS	All ages, Both	[redacted]	[redacted]	[redacted]

Overall Average Capitation for all Health Networks. Actual capitation paid is allocated based on the relative risk profiles of the Health Networks, in accordance with CalOptima policy. The Parties agree that the above rates compensate Physician for all services outlined in Attachment A, *CalOptima Medi-Cal Division of Financial Responsibility*, including ongoing compensation for COVID-19 diagnostic and screening testing services. The Parties further agree that future amendments to the Contract increasing the above rates due to a declared public health emergency shall constitute a negotiated and agreed upon new provision to the Contract delegating financial responsibility to Physician to cover the additional Medi-Cal Covered Services required by such declared public health emergency.

Supplemental OB Delivery Care Payment will be payable for all qualified deliveries based on DHCS guidance.

	Hospital	Physician	Total Capitation
Supplemental OB Delivery Care Payment - All	[redacted]	[redacted]	[redacted]

Capitation Rate Exclusions: In accordance with Section 14.20 of this Contract, ethical and religious directive services related to abortions, contraception and sterilization are excluded from the capitation rates specified in this Attachment E and shall be the financial responsibility of CalOptima. Claims for other services that are deemed as ethical and religious directive related services by Physician shall be forwarded to CalOptima for processing and CalOptima shall cap-deduct the cost of such Clean Claims from the Physician's prospective monthly capitation payment but no later than 90 calendar days following CalOptima's receipt of the Clean Claims. Should the servicing provider dispute the payment amount and CalOptima agrees to pay additional amount to the servicing provider, CalOptima shall cap deduct the additional amount from Physician's prospective monthly capitation payment within 90 days from CalOptima's decision of the dispute. Such cap-deduction shall include the amount and claim number (or other similar identifier) for each Clean Claim. Physician shall have 90 calendar days to contest any cap deductions. If CalOptima agrees with Physician's findings, CalOptima shall refund Physician such erroneous cap deductions. If CalOptima disagrees, the parties shall meet and confer to resolve any discrepancies.

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ATTACHMENT E-2

Shared Risk Program

1. Shared Risk Pool. CalOptima and Physician are establishing the Shared Risk Pool as described in CalOptima Policy FF.1010, Shared Risk Pool, which shall be administered by CalOptima and separately accounted for on CalOptima's books. As provided in the previous contract, any Shared Risk Pool deficits remaining at the end of the reconciliation of the final year of the previous contract and any expenses from a previous Shared Risk Period received after the end of that previous Shared Risk Pool reconciliation period shall be carried forward in the Shared Risk Pool under this Contract. Any deficits remaining at the end of the reconciliation of the final year of this Contract and any late-received expenses for that final year shall similarly be carried forward to any subsequent shared risk contract.

   1.1 Shared Risk Services—Definition. Shared Risk Services means all Covered Services that are designated under the caption "Hospital Budget" set forth in Attachment A of this Contract. The amounts or rates that CalOptima will pay to Hospitals for the provision of Shared Risk Services to Members are set forth in the Hospital Services Contract entered into with the participating Hospitals ("Shared Risk Hospital Amount(s)"). Non-Hospital providers of services contained within the "Hospital Budget" shall be paid according to their individual contract rates. Payments made to Hospitals under CalOptima's Health Network carve-out programs, such as "high-cost exclusions", shall not be included in Shared Risk Services.

   1.2 Shared Risk Budget. In addition to the Hospital Budget Capitation Allocation to the Shared Risk Pool set forth in Section 1 of this Attachment, the Shared Risk Budget shall include the following amounts received by CalOptima or any Hospital in connection with any Shared Risk Services provided to Members: (a) supplemental obstetrics (OB) delivery care payments as set forth in CalOptima Policy FF.1005f, Special Payments: Supplemental OB Delivery Care Payment, and (b) per CalOptima Policy FF.1007, Health Network Reinsurance Coverage, any reinsurance coverage amounts collected or allocated. Shared Risk Costs shall be the actual amounts paid for Shared Risk Services less any recoveries, including, but not limited to, overpayments. The Shared Risk Budget shall not include any amounts for Members eligible for the WCM Program.

   1.3 Shared Risk Expenses. Monthly, during the term of this Contract, the following expenses and charges ("Shared Risk Expenses") shall be deducted from the Shared Risk Budget: (a) the actual Shared Risk Hospital Amounts paid to Hospitals for Shared Risk Services provided to Members, (b) an estimated amount of IBNR expense (defined below) as reasonably determined by CalOptima (with the final IBNR expense determined in accordance with and as set forth in Section 1.5.1 below), and (c) administrative expenses at a rate of one dollar and sixty cents ($1.60) per Member per month. Any applicable copayments, deductibles or third-party payments collected by CalOptima or Hospitals for Shared Risk Services provided to Members shall be deducted from Shared Risk Expenses. The Shared Risk Expenses shall not include any amounts paid for Members eligible for the WCM Program.

   1.4 Shared Risk Pool – Quarterly Report and Semi-Annual Reconciliation and Adjustment.

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1.4.1 Within forty-five (45) days following the end of each calendar quarter during each Shared Risk Period (defined below), CalOptima shall produce a written report showing all allocations, deposits, expenses and disbursements with respect to the Shared Risk Pool during that quarter and the Shared Risk Period to date. Each quarterly Report shall include an estimate of the projected Budget Deficit or Budget Surplus (as such terms are defined in, and as determined consistent with, Section 1.5) determined by annualizing the aggregate amount of the Shared Risk Budget and the Shared Risk Expenses for all months to date in the applicable Shared Risk Period.

1.4.2 Within sixty (60) days of the end of the semi-annual distribution period, which shall be defined as July 1 through December 31 of each Shared Risk Period, CalOptima shall compute the status of the Shared Risk Pool for that semi-annual period as follows: Hospital Budget Allocations made in that semi-annual period minus claims paid for services rendered in that semi-annual period minus a full allocation for Incurred But Not Reported (IBNR) claims based on historical experience with the applicable CalOptima population for that semi-annual period. If the status thus computed shows a surplus, CalOptima shall pay to Physician, from the Hospital Budget Allocation, an amount equal to sixty percent (60%) of such surplus. Any surplus distributions are an advance against the projected final surplus. If the amount is a deficit, it shall be carried forward to the year-end reconciliation.

1.5 Shared Risk Pool -- Year-End Reconciliation and Settlement. The Shared Risk Pool shall be administered on a fiscal-year basis (July 1 through June 30) ("Shared Risk Period").

1.5.1 Within one hundred twenty (120) days following the close of each Shared Risk Period, CalOptima shall audit and reconcile, and produce a written report thereof, all allocations, deposits, expenses and disbursements with respect to the Shared Risk Pool. Risk Pool Expenses for any Shared Risk Period identified after the audit, reconciliation and settlement of the Shared Risk Pool for the applicable Shared Risk Period shall be rolled forward to the next succeeding Shared Risk Period. The reconciliation and settlement of the Shared Risk Pool shall take into account incurred but not reported ("IBNR") expenses, regardless of when paid, provided that only those expense items received within (90) days after the end of the current Shared Risk Period shall be included in the computation of the IBNR expense for such Shared Risk Period.

1.5.2 Deficit. If, for any Shared Risk Period, Shared Risk Expenses exceed the Shared Risk Budget (such excess referred to herein as the "Budget Deficit"), an amount equal to sixty percent (60%) of such Budget Deficit, plus the amount of any Semi-Annual distributions, shall be carried forward as a charge against any future distributions under Section 1.5.3.

1.5.3 Surplus. If, for any Shared Risk Period, the Shared Risk Budget exceeds the Shared Risk Expenses (such excess referred to herein as the "Budget Surplus"), an amount equal to sixty percent (60%) of such Budget Surplus shall be paid to Physician by CalOptima only after any Semi-Annual distributions have been deducted from the sixty percent (60%) of the Budget Surplus allocable to Physician.

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1.5.4 If Physician elects to move from existing contracted shared risk group model to another contract model, Physician's shared risk pool shall not be in deficit.

2. Reports and Timely Settlement. CalOptima shall be responsible for maintenance of records and development of reports required for administration of the Shared Risk Pool.

Physician shall have thirty (30) days following receipt to review annual reports produced by CalOptima under Section 1.5.1 above. Absent reasonable objections in such thirty (30) day period, such annual reports shall be considered final, and any and all payments of Budget Surplus shall be made within fifteen (15) days following the expiration of the 30 day review period.

3. Settlement in the Event of Termination**.** Notwithstanding anything in this Attachment or elsewhere in this Contract, if this Contract is terminated, in accordance with the provisions of Article 13 of this Contract, the Shared Risk Pool shall be settled within one hundred twenty (120) calendar days following the termination of this Contract in accordance with Section 1.5 of this Attachment.

4. Obligations of Physician. Within seventy-two (72) hours following notification of an admission of a Member to any Hospital, Physician shall provide CalOptima with a report in a form acceptable to CalOptima. If, in CalOptima's reasonable opinion, Physician consistently fails to provide such reports to CalOptima, Physician shall be deemed in breach of this Contract, and CalOptima may take all actions permitted under this Contract, including termination of this Contract for cause.

5. Prohibition on Other Agreements with Hospitals. During the term of this Contract, Physician shall not enter into any agreement with any Hospital with respect to the Members assigned to Physician without the prior written approval of CalOptima, and upon any violation of this provision by Physician, this Contract shall be subject to termination pursuant to Section 13.1. of the Contract.

6. IBNR Calculations. For purposes of this Contract, IBNR shall be calculated using Medi-Cal population lag studies to generate completion factors to apply against claims paid to date. If membership is significant enough or if there is a significant change in bed days, as determined by CalOptima, then alternative calculations may be used. Year-end IBNR will be calculated using claims paid data through ninety (90) days after the end of the Shared Risk Period. The year-end settlement report will note the "claims paid through" date, and subsequent claims paid for that Shared Risk Period will be recorded against the next Shared Risk Period.

7. Termination for Poor Performance. Budget Deficits in two successive Shared Risk Periods shall, at CalOptima's sole discretion, constitute cause for termination under Section 13.1.

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ATTACHMENT E-4

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ATTACHMENT F –1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

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ATTACHMENT F – 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB

0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: contract grant cooperative agreement loan loan guarantee loan insurance	2. Status of Federal Action: bid/offer/application initial award post-award	3. Report Type: initial filing material change For Material Change Only: Year _____ quarter_____ date of last report

4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned	13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:
Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

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INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

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ATTACHMENT G
CALIFORNIA REGULATORY REQUIREMENTS

This Attachment G sets forth the Medi-Cal program requirements and other California statutory and regulatory provisions applicable to this Contract. In the event of a conflict between this Attachment G and any other provision in the Contract, the provisions in this Attachment G control.

1. Definitions.

1.1 "**Downstream Subcontractor**" means an individual or an entity that has an agreement with a Subcontractor or a Downstream Subcontractor that includes a delegation of Physician's and Subcontractor's duties and obligations under the Contract.

1.2 "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one or more of the following: (i) placing the Member's health in serious jeopardy; (ii) serious impairment of bodily functions; (iii) serious dysfunctions to any bodily organ or part; or (iv) death.

1.3 "Intentionally left blank"

1.4 "Intentionally left blank"

1.5 "**Health Equity**" means the reduction or elimination of health disparities, health inequities, or other disparities in health that adversely affect vulnerable populations.

1.6 "**Laws**" means, without limitation, federal, state, tribal, or local statutes, codes, orders, ordinances, and regulations applicable to this Attachment G.

1.7 "**Quality Improvement and Health Equity Transformation Program**" or "**QIHETP**" means the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in Laws, Government Program Requirements.

2. Compliance with Laws. This Contract shall be governed by and construed in accordance with all Laws and applicable regulations governing the DHCS Contract, including 42 Code of Federal Regulations ("**CFR**") § 438.230; the Knox Keene Act, Health and Safety ("**H&S**") Code §§ 1340 *et seq*., unless otherwise excluded under the DHCS Contract; 28 CCR §§ 1300.43 *et seq*; Welfare & Institutions ("**W&I**") Code §§ 14000 and 14200 *et seq*.; and 22 CCR §§ 53800 *et seq.*, 53900 *et seq*. Physician will comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, including all applicable requirements specified in the DHCS Contract, Laws, sub-regulatory guidance, and DHCS All Plan Letters ("**APLs**") and policy letters, and CalOptima Policies. Physician shall comply with all monitoring requirements of the Contract, the DHCS Contract, and any other monitoring requests by DHCS and CalOptima. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.4), (A.5), (A.11), (B.7), (B.8), and (B.11)]

3. Provider Data. As applicable, Physician and its Subcontractors will submit to CalOptima complete, accurate, reasonable, and timely provider data, Program Data, Template Data, and any other reports or data as requested by CalOptima to meet its reporting requirements to DHCS. Physician shall submit all provider data to CalOptima in the form, format, and timeframe requested by CalOptima. Physician will make corrections to provider data as requested by CalOptima. Physician data shall include all data required under the Contract – including reports and Physician rosters. For purposes of this section, (1) "**Program Data**" means data that includes but is not limited to: Grievance data, Appeals data, medical exemption request denial reports and other continuity of care data, out-of-

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network request data, and PCP assignment data as of the last calendar day of the reporting month; and (2) "**Template Data**" means data reports submitted to DHCS by CalOptima, which includes, but is not limited to: data of Member populations, health care benefit categories, or program initiatives. [DHCS Contract, Exhibit A, Attachment III, §§ 1.2.5, 2.1.4, 2.1.5, 2.1.6, 3.1.5(A.6) and (B.10)]

4. Encounter Data. As applicable, Physician will submit to CalOptima complete, accurate, reasonable, and timely Encounter Data requested by CalOptima in order to meet its reporting requirements to DHCS in compliance with applicable DHCS APLs, including APL 14-020 and any superseding or amendment APLs. All Encounter Data shall be submitted to CalOptima no later than ninety (90) days from the Date of Service in the form and format as designated by CalOptima. Physician will cooperate as requested by CalOptima if corrections to Encounter Data are required for CalOptima to comply with reporting requirements to DHCS. [DHCS Contract, Exhibit A, Attachment III, §§ 2.1.2, 3.1.5(A.6) and (B.10)]

5. Reports. Physician, and its Participating Providers, agree to submit all reports required and requested by CalOptima to comply with applicable laws in a form acceptable to CalOptima. [DHCS APL 19-001, Attachment A, Requirement 6]

6. California Health and Human Services ("**CalHHS**") Data Exchange. Physician shall (i) execute the CalHHS Data Sharing Agreement ("**DSA**"), (ii) comply with the DSA requirements, including the CalHHS policies and procedures incorporated into the DSA, and (iii) participate in the real-time exchange of, or provision of access to, health information between and among other DSA participants, including CalOptima and any other Providers providing services to Members. [H&S Code § 130290]

7. Additional Subcontracting Requirements. If Physician is allowed to subcontract services under this Contract and does so subcontract, then Physician shall, upon request, provide copies of such Subcontracts to CalOptima and/or DHCS.

   7.1 Subcontracts for Provision of Covered Services. Physician shall maintain copies of all contracts it enters into related to ordering, referring, or rendering Covered Services under the Contract. Physician will ensure that such contacts are in writing. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.7)]

   7.2 Subcontracts. Physician shall require all Subcontracts and downstream Subcontracts that relate to the provision of Covered Services be in writing and include all applicable provisions of the Contract and this Medi-Cal Program Addendum including:

      7.2.1 The services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

      7.2.2 As applicable, Section 2, *Compliance with Laws*; Section 3, *Provider Data*; Section 4, *Encounter Data*; Section 7, *Additional Subcontractor Requirements*; Section 8, *Records Retention*; Section 9, *Access to Books and Records*; Section 10, *Records Related to Recovery for Litigation*; Section 11, *Transfer*; Section 12, *Unsatisfactory Performance*; Section 13, *Hold Harmless*; Section 14, *Prohibition on Member Claims and Member Billing*; Section 15, *Prospective Requirements*; Section 16, *Network Provider Training*; Section 17, *Language Assistance and Interpreter Services*; Section 18, *Fraud, Waste, and Abuse Reporting*; Section 19, *Provider Identified Overpayments*; Section 20, *Health Care Provider's Bill of*

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Rights; Section 21, *Provider Grievances*; Section 22, *Effective Dates*; Section 23, *Assignment and Sub-delegation*; Section 24, *Quality Improvement & Utilization Management*; Section 25, *Emergency Services and Post-Stabilization Delegation*; Section 28, *Amendment and Termination*; Section 29, *Delegated Activities*; Section 30, *Utilization Data*; Section 59, *DHCS Beneficiary*; and any other section of this Attachment G that is applicable to the obligations Subcontractor has undertaken.

7.2.3 An agreement that Subcontractors shall notify Physician of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

7.2.4 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 14.12 of the base Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

[DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.12)]

8. Records Retention. Physician and Subcontractors shall maintain and retain all books and records of all items and services provided to Members, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term of at least ten (10) years from the final date of the DHCS Contract, or from the date of completion of any audit, whichever is later. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Physician's books and records shall be maintained within, or be otherwise accessible within, the State and pursuant to H&S Code § 1381(b). Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima and/or representatives of any regulatory or law enforcement agency immediate and direct access and inspection of all such records at the time of any onsite audit or review.

This provision shall survive the expiration or termination of this Contract.

[DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.9) and (B.14); H&S Code § 1381; 28 CCR 1300.81]

9. Access to Books and Records. Physician agrees, and shall ensure its Subcontractors agree in Subcontracts, to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining directly or indirectly to the goods and services furnished under the terms of the Contract available for the purpose of an audit, inspection, evaluation, examination or copying at any time (i) in accordance with inspections and audits as directed by CalOptima, Regulators, the Department of Justice ("**DOJ**"), Office of Attorney General Division of Medi-Cal Fraud and Elder Abuse ("**DMFEA**"), DHCS's External Quality Review Organization contractor, and any other State or federal entity and their duly authorized designees statutorily entitled to have oversight responsibilities over CalOptima and/or Physician and its Subcontractors; (ii) at all reasonable times at Physician's and Subcontractor's respective places of business or at such other mutually agreeable location in the State; and (iii) in a form maintained in accordance with the general standards applicable to such book or record keeping. Physician and Subcontractors shall provide access to all security areas and facilities and cooperate and assist State representatives in the performance of their duties. If DHCS, CMS, DMFEA, or DOJ or any other authorized State or federal agency, determines there is a credible allegation of fraud against Physician, CalOptima reserves the right to suspend or terminate the Physician from participation in the Medi-Cal program;

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immediately suspend payments to Physician; seek recovery of payments made to Physician or any Subcontractor; impose other sanctions provided under the DHCS Contract, and conduct additional monitoring.

Physician and Subcontractors shall cooperate in the audit process by signing any consent forms or documents required by but not limited to: DHCS, DMHC, the DOJ, Attorney General, Federal Bureau of Investigation, Bureau of Medi-Cal Fraud, and/or CalOptima to release any records or documentation Physician may possess in order to verify Physician's records.

This provision shall survive the expiration or termination of this Contract and Subcontractors. [DHCS Contract, Exhibit A, Attachment III, § 1.3.4.(D), § 3.1.5(A.8) and (B.13); Exhibit E, § 1.1.22(B); APL 19-001, Attachment A; APL 17-001]

10. Records Related to Recovery for Litigation. Upon request by CalOptima, Physician shall timely gather, preserve and provide to CalOptima, DHCS, CMS, DMFEA, and any authorized State or federal agency in the form and manner specified by such entity, any information, subject to any lawful privileges, in Physician's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Physician asserts that any requested documents are covered by a privilege, Physician shall: (i) identify such privileged documents with sufficient particularity to reasonably identify the documents while retaining the privilege; and (ii) state the privilege being claimed that supports withholding production of the document. Physician agrees to promptly provide CalOptima with copies of any documents provided to any party in any litigation by or against CalOptima or DHCS. Physician acknowledges that time is of the essence in responding to such requests. Physician shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records received by Physician or its Subcontractors related to this Contract or Subcontracts. Physician further agrees to timely gather, preserve, and provide to DHCS any records in Physician's or its Subcontractor's possession. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.10) and (B.15); Exhibit E, § 1.1.27]

11. Transfer. Physician agrees, and will require its Subcontractors to assist, CalOptima in the transfer of Member care if in the event of: (i) termination of the DHCS Contract for any reason in accordance with the terms of the DHCS Contract; (ii) termination of this Contract for any reason; or (iii) a Subcontract terminates for any reason. Such assistance will include making available to CalOptima and DHCS copies of each Member's medical records and files, and any other pertinent information necessary to provide affected Members with case management and continuity of care. Such records will be made available at no cost to CalOptima, DHCS, or Members. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.11) and (B.16); Exhibit E, § 1.1.17(B)]

12. Unsatisfactory Performance. Physician agrees that the Contract or Physician's participation in the Medi-Cal program will be terminated, or subject to other remedies, if DHCS or CalOptima determine that Physician has not performed satisfactorily. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.12)]

13. Hold Harmless. Physician and its Subcontractors shall accept CalOptima's payment as described in this Contract as payment in full for all Covered Services and Administrative Services. Physician and its Subcontractors agree to hold harmless both the State and Members in the event that CalOptima cannot or will not pay for obligations undertaken by Physician pursuant to this Contract. This provision does not [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.13) and (B.18)]

14. Prohibition on Member Claims and Member Billing. Physician and its Subcontractors will not bill or otherwise collect reimbursement from a Member for any services provided under this Contract. Physician and Subcontractors will ensure that Members are not balance billed for any service provided out of network. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.14), 3.3.6, 5.2.7]

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15. Prospective Requirements. CalOptima will inform Physician of prospective requirements added by State or federal law, or DHCS to the DHCS Contract that would impact Physician's obligations before the requirement becomes effective. Physician agrees to comply with the new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by CalOptima or DHCS. Physician will ensure Subcontractors are (i) informed of prospective requirements that would impact their obligations before the requirements become effective and (ii) agree to comply with new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by CalOptima or DHCS. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.15), (B.22), and (B.23)]

16. Network Provider Training. Physician shall participate in training required by CalOptima in order for CalOptima to comply with the DHCS Contract. Such provider training may include, utilization management training, quality of care for children (early periodic screening, diagnosis and testing) training, Member's rights, and advanced directives. Training will also include training on cultural competency and linguistic programs as outlined in this section. Physician shall ensure that all Subcontractors receive all applicable training. [DHCS Contract, Exhibit A, Attachment III, §§ 2.3(F), 3.2.5, 5.1.1, 6.1.3(C)]

    16.1 Diversity, Health Equity, Cultural Competency, and Sensitivity Training. Physician shall ensure that annual diversity, Health Equity, cultural competency/humility, and sensitivity training is provided for employees and staff at key points of contact, pursuant to the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.16) and (B.24), 5.2.11(C)]

    16.2 Cultural/Linguistic Training Programs. Physician shall participate in and comply with any applicable performance standards, policies, procedures, and programs established from time to time by CalOptima and federal and State agencies and provided or made available to Physician with respect to cultural and linguistic services, including attending training programs and collecting and furnishing cultural and linguistic data to CalOptima and federal and State agencies. [DHCS Contract, Exhibit A, Attachment III, § 5.2.11]

    16.3 Discharge Planning and Transitional Care Training. Physician will educate its discharge planning staff on the services, supplies, medications, and durable medical equipment requiring prior authorization, and CalOptima's policies regarding discharge planning and transitional care services, as applicable. [DHCS Contract, Exhibit A, Attachment III, § 4.3.10(A.6) and (A.7)]

17. Language Assistance and Interpreter Services. Physician and its Subcontractors will comply with language assistance standards developed pursuant to H&S Code § 1367.04 and the DHCS Contract. Physician agrees to provide or arrange for the provision of interpreter services for Members. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.17) and (B.25), 5.1.3(F)]

18. Fraud, Waste, and Abuse Reporting. Physician shall report suspected fraud, waste, or abuse to CalOptima in accordance with the Contract. Physician agrees to provide CalOptima with all information reasonably requested by CalOptima, DHCS, or other State and federal agencies with jurisdiction in order for CalOptima to comply with fraud, waste, or abuse investigations and reporting requirements. In the course of a fraud, waste, or abuse investigation, CalOptima may share with Physician information that DHCS has disclosed to CalOptima ("**FWA Confidential Data**"). Physician acknowledges and agrees to maintain FWA Confidential Data confidentially. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.2(D), 3.1.5(A.18) and (B.26)]

19. Provider Identified Overpayments. In addition to Overpayment requirements under the Contract, Physician shall report in writing to CalOptima when it has received an Overpayment, identify the

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reason for the Overpayment, and promptly return the overpayment to CalOptima as outlined within sixty (60) days of the date Physician identified the Overpayment. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.6, 3.1.5(A.19), (B.27)]

20. Health Care Providers' Bill of Rights. Notwithstanding anything in this Contract to the contrary, Physician shall be entitled to the protections of the Health Care Providers' Bill of Rights, as set forth in H&S Code § 1375.7, in the administration of this Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.20)]

21. Provider Grievances. Physician has the right to submit a dispute or grievance through CalOptima's formal process to resolve provider disputes and grievances pursuant to H&S Code § 1367(h)(1). CalOptima's process to resolve Physician disputes or grievances are set forth in this Contract and the CalOptima Policies. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.20), 3.2.2(B)]

22. Effective Dates. This Contract and its amendments will become effective only as set forth in the DHCS Contract, which requires filing and approval by DHCS of template contracts and amendments, and Subcontractor and Downstream Subcontractor agreements and amendments. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.2, 3.1.5(B.4)]

23. Assignment and Sub-delegation. Physician agrees that any assignment or delegation of an obligation or responsibility under this Contract by Physician to a Subcontractor shall be void unless prior written approval is obtained from CalOptima and DHCS. Physician further agrees that assignment or delegation by a Subcontractor is void unless prior written approval is obtained from DHCS. CalOptima or DHCS may withhold consent at their sole and absolute discretion. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.5) and (B.6); APL 19-001, Attachment A, Requirement 14]

24. Quality Improvement & Utilization Management. Physician agrees to cooperate and participate in CalOptima's QMI program including participating in QI Program, UM Program, QIHETP, and population needs assessments. [DHCS Contract, Exhibit A, Attachment III, §§ 2.2.4, 3.1.5(B.19)]

25. Emergency Services and Post-Stabilization.

25.1 Delegation. Physician must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has an agreement with Physician.

25.1.1 Physician must not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR § 438.114(a)(i)-(iii). Further, Physician must not deny payment for treatment obtained when a representative of Physician instructs the Member to seek Emergency Services. Emergency Services must not be subject to prior authorization by Physician.

25.1.2 Physician must not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms or refuse to cover Emergency Services based on the emergency department provider, Physician, or fiscal agent not notifying Physician, the Member's PCP, CalOptima, or DHCS of the Member's screening and treatment for Emergency Services. A Member who has an Emergency Medical Condition must not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the Member.

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25.2 Non-Contracting Physician Emergency Services Payment.

25.2.1 Physician shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Physician, or the Member is stabilized sufficiently to permit discharge. The treating provider is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on Physician. Emergency Services shall not be subject to prior authorization by Physician.

25.2.2 At a minimum, Physician must reimburse the non-contracting emergency department and, if applicable, its affiliated providers for physician services at the lowest level of emergency department evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

25.2.3 For all non-contracting providers, reimbursement by Physician or its Subcontractor who is at risk for out-of-plan Emergency Services, for properly documented claims for services rendered by a non-contracting provider pursuant to this provision shall be made in accordance with the DHCS Contract, 42 USC § 1396u-2(b)(2)(D), W&I Code § 14091.3, and other Laws.

25.3 Post-Stabilization Care Services. Except for response time periods set forth in 42 CFR 422.113(c)(2)(ii) and (iii)(A), Physician will pay for post-stabilization care services in accordance with 42 CFR § 422.113(c) and DHCS APL 23-009 (and any successor guidance). Physician is financially responsible for post-stabilization care services obtained within or outside of Physician's network that are authorized by Physician, Subcontractors, or Downstream Subcontractors.

25.3.1 In accordance with 28 CCR § 1300.71.4, Physician must approve or disapprove a request for post-stabilization care services made by a provider on behalf of a Member within thirty (30) minutes of the request. If Physician fails to approve or disapprove authorization within the required timeframe, the authorization is deemed approved.

25.3.2 Physician is also financially responsible for post-stabilization care services obtained within or outside of Physician's network that are not authorized by Physician, Subcontractor, or a Downstream Subcontractor but administered to maintain, improve, or resolve the Member's stabilized condition if Physician, Subcontractor, Downstream Subcontractor, or a Participating Physician do not respond to a request for authorization within thirty (30) minutes; Physician, Subcontractor, Downstream Subcontractor or Participating Physician cannot be contacted; or Physician, Subcontractor, or Downstream Subcontractor and the treating provider cannot reach an agreement concerning the Member's care. In this situation, the treating provider may continue with care of the Member until Physician, Subcontractor, or Downstream Subcontractor is reached and assumes responsibility for the Member's care or one of the criteria of 42 CFR § 422.113(c)(3) is satisfied.

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25.3.3 Physician's financial responsibility for post-stabilization care services it has not authorized ends when a Participating Provider with privileges at the treating Physician assumes responsibility for the Member's care, a Participating Provider assumes responsibility for the Member's care through transfer, Physician's representative and the treating provider reach an agreement concerning the Member's care; or the Member is discharged.

25.3.4 Consistent with 42 CFR §§ 438.114(e), 422.113(c)(2), and 422.214, Physician is financially responsible for payment of post-stabilization care services, following an emergency admission, at the Physician's Medi-Cal FFS payment rates for general acute care inpatient services rendered by a non-contracting, Medi-Cal certified Physician, unless a lower rate is agreed to in writing and signed by the Physician.

25.3.4.1 For the purposes of this Section 25, the Medi-Cal FFS payment amounts for dates of service when the post-stabilization care services were rendered must be the Medi-Cal FFS payment method known as diagnosis-related groups, which for the purposes of this Section 25.3.4 must apply to all acute care Physicians, including public Physicians that are reimbursed under the certified public expenditure basis methodology (W&I Code § 14166 *et seq.*), less any associated direct or indirect medical education payments to the extent applicable.

25.3.4.2 Payment made by Physician to a Physician that accurately reflects the payment amounts required by this Section 25.3.4 shall constitute payment in full, and must not be subject to subsequent adjustments or reconciliations by Physician, except as provided by Medicaid Laws. A Physician's tentative and final cost settlement processes required by 22 CCR § 51536 shall not have any effect on payments made by Physician pursuant to this Section 25.3.4.

25.4 Emergency Services or Post-Stabilization Claims Disputes. Disputed Emergency Services or post-stabilization care services claims may be submitted to DHCS, Office of Administrative Hearings and Appeals, 3831 North Freeway Blvd, Suite 200, Sacramento, CA 95834, for resolution under W&I Code § 14454 and 22 CCR § 53620 *et seq*. (except 22 CCR § 53698). Physician agrees to abide by the findings of DHCS in such cases, to promptly reimburse the non-contracting provider within thirty (30) calendar days of the effective date of a DHCS decision and to provide proof of reimbursement in such form as the DHCS Director may require. Failure to reimburse the non-contracting provider and provide proof of reimbursement to DHCS within thirty (30) calendar days shall result in liability offsets in accordance with W&I Code §§ 14454(c) and 14115.5 and 22 CCR § 53702 and may subject Physician to sanctions pursuant to W&I Code § 14197.7.

[DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.9)]

26. Telehealth. When providing any Covered Services through telehealth and/or subsequently billing for telehealth Covered Services, Physician shall ensure that it complies with all applicable statutory and regulatory requirements, including H&S Code § 1374.13; W&I Code §§ 14132.72, 14132.100, and 14132.725; Business & Professions Code § 2290.5, and DHCS APL 23-007 (and any successor guidance) (collectively "**Telehealth Requirements**"). These Telehealth Requirements include (i) obtaining and documenting Member consent to use telehealth; (ii) ensuring the services can be appropriately delivered via telehealth; (iii) offering telehealth services via in-person, face-to-face

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interactions, as well, or arranging for referrals and facilitating in-person care so that a Member does not have to independently contact a different Provider; (iv) establishing all new patients through telehealth using an approved methodology; (v) complying with all privacy and confidentiality laws in rendering services; and (vi) satisfying the required documentation and coding requirements, as further outlined in CalOptima Policies. Claims for Covered Services provided through telehealth may not be reimbursable if they do not comply with these Telehealth Requirements.

27. Electronic Prescriptions. Physician's Participating Providers who may issue prescriptions under Business & Professions Code § 4040(a) shall have the capacity to prescribe electronically and shall issue electronic prescriptions in accordance with Business & Professions Code § 688.

28. Amendment and Termination. Physician agrees to notify DHCS if this Contract or an agreement with a Subcontractor is amended or terminated for any reason. For purposes of this section, notice is considered given when the notice is properly addressed and deposited in the United States Postal Service as first-class registered mail, postage prepaid. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.17); APL 19-001, Attachment A, Requirement 13]

29. Delegated Activities. If Physician is specifically delegated by CalOptima, delegated activities and reporting requirements will be further set forth in a separate attachment or addendum to this Contract. Such delegation may include, claims processing, utilization management, quality improvement, Health Equity activities, credentialing activities, and any other obligation that CalOptima is permitted to delegated to Physician, to the extent agreed upon between CalOptima and Physician. Physician agrees to perform and will require its Subcontractors to perform the obligations and functions of CalOptima undertaken pursuant to the Contract, including but not limited to reporting responsibilities, in compliance with CalOptima's obligations under the DHCS Contract in accordance with 42 CFR § 438.230(c)(1)(ii). Physician agrees to the revocation of the delegated activities and/or obligations, and/or any other specific remedies in instances where DHCS or CalOptima determine that Physician has not performed satisfactorily. If CalOptima delegates quality improvement activities, the Parties agree that the Contract will include provisions that address, at a minimum: (i) quality improvement responsibilities, and specific delegated functions and activities of CalOptima and Physician; (ii) CalOptima's oversight, monitoring, and evaluation processes and Physician's agreement to such processes; (iii) CalOptima's reporting requirements and approval processes, including, Physician's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly; and (iv) CalOptima's actions/remedies if Physician's obligations are not met. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.1, 3.1.5(B.1), (B.8), (B.20), and (B.28); APL 19-001, Attachment A, Requirement 22]

30. Utilization Data. If and to the extent that the Physician is responsible for the coordination of care for Members, CalOptima shall share with Physician, in accordance with the appropriate Declaration of Confidentiality signed by Physician and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Physician shall receive the utilization data provided by CalOptima and use solely for the purpose of Member care coordination. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.21); APL 19-001, Attachment A, Requirement 23]

31. Medical Decisions. Physician will ensure that medical decisions or any course of treatment in the provision of Covered Services by Physician, Subcontractors, or Downstream Subcontractors are not unduly influenced by fiscal and administrative management. [DHCS Contract, Exhibit A, Attachment III, § 1.1.5]

32. Capacity, Licensure, and Enrollment. Physician and its Subcontractors shall furnish to Medi-Cal Members those Medically Necessary Covered Services that Physician and Subcontractor is authorized to provide under this Contract, consistent with the scope of Physician's and/or

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Subcontractor's license, certification, and/or accreditation, and in accordance with professionally recognized standards. Physician and its Subcontractors agree to comply with required provider screening, enrollment, and credentialing and recredentialing requirements. Physician warrants that it has and shall maintain through the Term adequate staff to comply with its obligations under the Contract and will require. [DHCS Contract, Exhibit A, Attachment III, § 1.3.3]

33. Medi-Cal Enrollment. If Physician is a provider type that is not able to enroll in Medi-Cal through the DHCS, Physician shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of 22 CCR § 51000.35.

34. Prohibition Against Payment to Excluded Providers. Physician agrees that CalOptima is prohibited from contracting with individuals excluded from participation in State or federal programs and agrees that CalOptima shall not pay Physician if Physician is excluded from State or federal programs, as outlined in Sections 3.31 and 5.12 of the Contract. Physician further agrees to not contract with or make payments to Subcontractors excluded from State or federal programs. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.4, 3.3.18]

35. Ownership Disclosure Statement. Prior to commencing services under this Contract, Physician shall provide CalOptima with the disclosures required by 42 CFR §§ 438.608(c)(2), 438.602(c), and 455.105, including the names of the officers and owners of Physician holding more than five percent (5%) of the stock issued by Physician, and major creditors holding more than five percent (5%) of the debt of Physician by completing the form in Attachment B, and Physician shall notify CalOptima whenever changes occur to the information provided therein. Physician shall promptly notify CalOptima of any change in the required disclosures. [DHCS Contract, Exhibit A, Attachment III, § 1.3.5; Exhibit E, § 1.1.11(A.5)]

    35.1 If Participating Provider is not eligible to enroll in Medi-Cal, Physician shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of 22 CCR § 51000.35 for its Participating Providers.

36. Performance Improvement Projects. Physician and Subcontractors shall comply with all applicable performance standards and participate in performance improvement projects ("**PIP**s"), including any collaborative PIP workgroups, as may be directed by CMS, DHCS, or CalOptima. [DHCS Contract, Exhibit A, Attachment III, § 2.2.9(A)-(B)]

37. No Punitive Action. CalOptima will not take punitive action against Physician if Physician requests an expedited resolution of or supports a provider or Member appeal. CalOptima will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member (i) for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, including any information the Member needs in order to decide among all relevant treatment options; (ii) for the risks, benefits, and consequences of treatment or non-treatment; (iii) for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment; and (iv) to express preferences about future treatment decisions. [DHCS Contract, Exhibit A, Attachment III, §§ 3.2.7, 4.6.5(A)]

38. Claims Processing. CalOptima will process claims in accordance with the DHCS Contract, H&S Code §§ 1371 through 1371.36 and their implementing regulations, and as outlined in the CalOptima Policies. If Physician is responsible for claims payments, Physician will pay claims consistent with this provision. [DHCS Contract, Exhibit A, Attachment III, § 3.3.5]

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39. Cost Avoidance/Other Health Coverage. Physician acknowledges that Medi-Cal is a payor of last resort except for services in which Medi-Cal is required to be the primary payer. Accordingly, CalOptima shall not pay claims for services provided to a Member who has third-party coverage without proof that Physician has first exhausted all other payment sources. Physician shall not refuse to provide Covered Services to Members when OHC is indicated in the Member's Medi-Cal eligibility record. Physician shall review the Member's eligibility record for third party coverage, and if the Member has third-party coverage, Physician must notify the Member to seek the service from the third-party coverage. [DHCS Contract, Exhibit E, § 1.1.25(G)]

40. Public Record. Notwithstanding any other term of the Contract, this Contract and all information received in accordance with the DHCS Contract will be public record on file with DHCS, except as specifically provided by Laws. DHCS ensures the confidentiality of information and contractual provisions filed with DHCS to the extent the information and provisions are specifically exempted by Laws. [DHCS Contract, Exhibit A, Attachment III, § 3.1.11]

41. Provider Preventable Condition. CalOptima will not pay Physician for a provider preventable condition as described in 42 CFR § 438.3(g). As a condition of payment, provider shall comply with reporting requirements on provider preventable conditions in the form and frequency specified by DHCS in APL 17-009 or any superseding APL. If Physician is delegated claims payments, Physician will ensure it does not pay for provider preventable conditions. [DHCS Contract, Exhibit A, Attachment III, § 3.3.17]

42. Member Rights. Physician and Subcontractors will not retaliate or take any adverse action against a Member for exercising the Member's rights under the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, § 5.1.1(A.1.r)]

43. Medical Records. All medical records shall be maintained in accordance with CalOptima Policies. Physician shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Subcontractor site. [DHCS Contract, Exhibit A, Attachment III, § 5.2.14]

44. Timely Access/Standards of Accessibility. Physician and Subcontractors will comply with applicable standards of accessibility and timely access requirements as outlined in the Contract and in CalOptima Policies. Physician and Subcontractors will comply with CalOptima's procedures for monitoring Physician's and Subcontractor's compliance with this section. [DHCS Contract, Exhibit A, Attachment III, § 5.2.5]

45. Minor Consent Services. Physician and its Subcontractors are prohibited from disclosing, and agree not to disclose, any information related to minor consent services without the express consent of the minor Member. Physician and its Subcontractors will comply with CalOptima's requirements for services to minor Members as outlined in the CalOptima Policies. [DHCS Contract, Exhibit A, Attachment III, § 5.2.8(D)]

46. Emergency Preparedness Requirements. Physician agrees to cooperate with and comply with CalOptima's Emergency requirements, CalOptima Policies, and training to ensure continuity of care for Members during an Emergency. For purposes of this section, "**Emergency**" means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by a public health crisis, natural and man-made hazards, or disasters. Physician will (i) annually submit to CalOptima evidence of adherence to CMS Emergency Preparedness Final Rule 81 Fed. Reg. 63859 and 84 Fed. Reg. 51732; (ii) advise CalOptima of Physician's Emergency plan; and (iii) notify CalOptima within twenty-four (24) hours of an Emergency if Physician closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an Emergency. [DHCS Contract, Exhibit A, Attachment III, §§ 6.1, 6.1.3(C)]

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47. State's Right to Monitor. Physician and Subcontractors shall comply with all monitoring provisions of this Contract, the DHCS Contract, and any monitoring requests by CalOptima and Regulators. Without limiting the foregoing, CalOptima and authorized State and federal agencies will have the right to monitor, inspect, or otherwise evaluate all aspects of the Physician's operation for compliance with the provisions of this Contract and Laws. Such monitoring, inspection, or evaluation activities will include inspection and auditing of Physician, Subcontractor, and Physician's and Subcontractors' facilities, management systems and procedures, and books and records, at any time, pursuant to 42 CFR § 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Physician. Access will be undertaken in such a manner as to not unduly delay the work of the Physician and/or the Subcontractor(s). [DHCS Contract, Exhibit D(f) § 8; Exhibit E, § 1.1.22(B)]

48. Laboratory Testing. Physician agrees that if any performance under this Contract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC § 263a and the regulations thereto. [DHCS Contract, Exhibit D(f), § 18]

49. Third Party Tort Liability. Physician and Subcontractors shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, worker's compensation, class action claims or casualty liability insurance awards and uninsured motorist coverage. Physician shall identify and notify CalOptima, within five (5) calendar days of discovery, which shall in turn notify DHCS, of any action by the CalOptima Member that may result in casualty insurance payments, tort liability, Workers' Compensation awards, class action claims, or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under W&I Code Article 3.5 (commencing with Section 14124.70), Part 3, Division 9. [DHCS Contract, Exhibit E, §§ 1.1.25 and 1.1.26]

50. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Physician's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least seventy-five (75) days prior to the proposed effective date. [Exhibit A, Attachment III, § 5.2.9]

51. Confidentiality of Medi-Cal Members.

51.1 Physician and its Subcontractors shall have policies and procedures in place to guard against unlawful disclosure of protected health information, personally identifying information, and any other Member confidential information in accordance with 45 CFR Parts 160 and 164, Civil Code §§ 1798 *et seq.* Physician and its Subcontractors shall obtain prior written authorization from the Member in order to disclose such information unless exempted by 22 CCR § 51009. [DHCS Contract, Exhibit A, Attachment III, § 5.1.1(B)]

51.2 In accordance with 42 CFR § 431.300 *et seq*., as well as W&I Code § 14100.2 and regulations adopted thereunder, Physician and its employees, agents, and Subcontractors shall protect from unauthorized disclosure the names and other identifying information, records, data, and data elements concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Physician, its employees, and/or agents as a result of services performed under

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this Contract, except for statistical information not identifying any such persons. Physician and its employees, agents, and Subcontractors shall not use or disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima.

51.2.1 Physician and its employees, agents, and Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Physician may release medical records in accordance with Laws pertaining to the release of this type of information. Physician is not required to report requests for medical records made in accordance with Laws.

51.2.2 With respect to any identifiable information concerning a Member under this Contract that is obtained by Physician or its Subcontractors, Physician will, at the termination or expiration of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Physician by CalOptima for this purpose.

51.2.3 For purposes of this Section 51.2, identity shall include the name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

[DHCS Contract, Exhibit D(f) § 14; Exhibit E, § 1.1.23]

52. Debarment Certification. By signing this Contract, Physician agrees to comply with applicable federal suspension and debarment regulations, including 2 CFR 180 and 2 CFR 376.

52.1 By signing this Contract, Physician certifies to the best of its knowledge and belief, that it and its principals:

52.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

52.1.2 Have not within a three (3)-year period preceding this Contract been convicted of or had a civil judgment rendered against them for: (i) commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; (ii) a violation of federal or State antitrust statutes; or (iii) commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any other offense indicating a lack of business integrity or business honesty that seriously affects its business honesty;

52.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of the offenses enumerated in Section 52.1.2, above;

52.1.4 Have not within a three (3)-year period preceding the Effective Date had one or more public transactions (federal, state, or local) terminated for cause or default;

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52.1.5 Have not, within a three (3)-year period preceding this Contract, engaged in any of the violations listed under 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376;

52.1.6 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (*i.e.*, 48 CFR Part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

52.1.7 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

52.2 If the Physician is unable to certify to any of the statements in this Section 52, Physician shall submit an explanation to CalOptima prior to the Effective Date and then immediately upon any change in the certifications above during the Term.

52.3 The terms and definitions in this Section 52 not otherwise defined in the Contract have the meanings set out in 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376.

52.4 If the Physician knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause.

[DHCS Contract, Exhibit (D)(f) § 20]

53. DHCS Directives. If required by DHCS, Physician and its Subcontractors shall cease specified services for Members, which may include referrals, assignment of beneficiaries, and reporting, until further notice from DHCS. [DHCS Contract, Exhibit (D)(f) § 34)]

54. Lobbying Restrictions and Disclosure Certification.

54.1 This Section 54 is applicable to federally funded contracts in excess of one hundred thousand dollars ($100,000) per 31 USC § 1352. If this Section 54 is applicable to the Contract, Physician shall comply with the requirements in this Section 54, as well as complete the disclosure forms in Attachment B prior to the Effective Date.

54.2 Certification and Disclosure Requirements.

54.2.1 If this Contract is subject to 31 USC § 1352 and exceeds one hundred thousand dollars ($100,000) at any tier, Physician shall file the certification and disclosure forms in Attachment E prior to the Effective Date.

54.2.2 Physician shall file a disclosure (in the form set forth in Attachment E, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if Physician has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant that would be prohibited under Section 54.3 if paid for with appropriated funds.

54.2.3 Physician shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by Physician

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under Section 54.2.2. An event that materially affects the accuracy of the information reported includes:

54.2.3.1 A cumulative increase of twenty-five thousand dollars ($25,000) or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

54.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

54.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

54.2.4 Each Subcontractor who requests or receives from Physician or Subcontractor a contract, subcontract, grant, or subgrant exceeding one hundred thousand dollars ($100,000) at any tier under this Contract shall file a certification, and a disclosure form, if required, to the next tier above that Subcontractor.

54.2.5 All disclosure forms (but not certifications) completed under this Section 54.2 and Attachment E shall be forwarded from tier to tier until received by CalOptima. CalOptima shall forward all disclosure forms to DHCS program contract manager.

54.3 Prohibition. 31 USC § 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

[DHCS Contract, Exhibit (D)(f) § 37.b]

55. Air or Water Pollution Requirements. Any federally funded agreement and/or Subcontract in excess of one hundred thousand dollars ($100,000) must comply with the following provisions unless said agreement is exempt by Laws. If applicable, Physician agrees to comply with all standards, orders, or requirements issued under the Clean Air Act (42 USC §§ 7401 *et seq*.), as amended, and the Clean Water Act (33 USC §§ 1251 *et seq*.), as amended. [DHCS Contract, Exhibit (D)(f) § 12]

56. Smoke-Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994, requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of eighteen (18), if the services are funded by federal programs either directly or through State or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to one thousand dollars ($1,000) for each violation and/or the imposition of an administrative compliance order on the responsible party. Physician shall comply with the

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applicable requirements of the Pro-Children Act. Physician further agrees that it will insert this certification into any Subcontracts, if required by the Pro-Children Act. [DHCS Contract, Exhibit (D)(f) § 21]

57. Domestic Partners. Pursuant to H&S Code § 1261, if Physician is licensed pursuant to H&S Code § 1250, Physician agrees to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child. [H&S Code § 1261]

58. Conflict of Interest. Physician agrees to avoid conflicts of interest or the appearance of a conflict of interest and shall (i) comply with conflict of interest avoidance requirements of the DHCS Contract; (ii) comply with any conflict avoidance plan issued by CalOptima; and (iii) notify CalOptima within ten (10) calendar days of becoming aware of any potential, suspected, or actual conflict of interest. [DHCS Contract, Exhibit H]

59. DHCS Beneficiary. Physician expressly agrees and acknowledges that (i) DHCS is a direct beneficiary of the Contract and any Subcontractor or Downstream Subcontractor agreement with respect to the obligations and functions undertaken under the Contract; and (ii) DHCS may directly enforce any and all provisions of the Subcontractor agreement or Downstream Subcontractor agreement. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.29)]

60. Employment Non-Discrimination. During the performance of this Contract, neither Physician nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, medical condition, mental disability, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, military and veteran status. Physician and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and shall comply with the provisions of the Fair Employment and Housing Act (Government Code §§ 12900 *et seq*.) and the applicable regulations promulgated thereunder (2 CCR §§ 11000 *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code § 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Physician and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Physician shall include the non-discrimination and compliance provisions of this Section 60 in all Subcontracts. [DHCS Contract, Exhibit E. § 1.1.28]

60.1 Physician and all Subcontractors shall comply with federal nondiscrimination requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973, as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations promulgated under the above-listed statutes. Physician and all Subcontractors shall comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, GC sections 7405 and 11135, W&I Code section 14029.91, and State implementing regulations. [DHCS Contract, Exhibit E. §1.1.29]

61. Member Non-Discrimination. Neither Physician nor Subcontractors shall discriminate against Members or Potential Members on the basis of any characteristic protected under federal or State nondiscrimination law, including sex, race, color, religion, ancestry, national origin, creed, ethnic

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group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code § 422.56, including the statutes identified in Section 60 above. For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service that is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting or harassing a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; (v) assigning times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code § 422.56, to the Members to be served; (vi) treating a Member or potential Member differently from others in determining whether they satisfy any admission, Enrollment, quota, eligibility, membership; or adding other requirements or conditions which Members must meet in order to be provided any Covered Service; (vii) utilizing criteria or methods of administration which have the effect of subjecting individuals to discrimination; (viii) failing to make auxiliary aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and (ix) failing to ensure meaningful access to programs and activities for limited English proficiency Members and potential Members.

61.1 Physician shall take affirmative action to ensure all Members are provided Covered Services without unlawful discrimination, except where needed to provide equal access to limited English proficiency Members or Members with disabilities, or where medically indicated. For the purposes of this Section 61, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

61.2 Physician shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Member Complaint Policy and shall forward copies of all such grievances to CalOptima, attention Grievance & Appeals Resolution Services, within five (5) days of receipt of same.

61.3 Physician shall require all Participating Providers to cooperate with CalOptima's Member Complaint Policy and time requirements to Appeal within designated time frames.

[DHCS Contract, Exhibit E §1.1.30]

62. Program Integrity and Compliance Program. Physician will establish a robust integrity and compliance program with administrative and management policies and procedures designed to prevent and detect fraud, waste, and abuse in compliance with the requirements of 42 CFR § 438.608. [DHCS Contract, Exhibit A, Attachment III, § 1.3]

63. Key Personnel Changes. Physician will report to CalOptima within ten (10) calendar days any changes in Physician's executive-level personnel, including the chief executive officer, chief financial officer, chief operations officer, the medical director, the chief health equity officer, or the compliance officer and government relations persons. Physician will also report to CalOptima

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changes in executive-level personnel of any Subcontractors and Downstream Subcontractors. [DHCS Contract, Exhibit A, Attachment III, § 1.1.8]

64. Medical Loss Ratio. Physician will comply with all applicable medical loss ratio requirements, including reporting and remittance requirements as required by DHCS and CalOptima. When reporting medical loss ratio, Physician will distinguish which amounts were actually paid for benefits or activities that improve health care quality and which amounts were actually paid for Administrative Services, taxes, or other activities in accordance with the Center for Medicaid and CHIP Services Informational Bulletin published May 15, 2019 with the subject "Medical Loss Ratio Requirements Related to Third-Party Vendors. [DHCS Contract, Exhibit A, Attachment III, § 1.2.5]

65. "Intentionally left blank"

66. Lead Screening. As applicable, Physician shall ensure the provision of a blood lead screening test to Members at ages and intervals specified in 17 CCR §§ 37000-37100 and applicable APLs. HMO will follow the Childhood Lead Poising in Prevention Branch guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including making referrals to the local public health department. Physician shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide the test in the Member's medical record. If the blood lead screen test is refused, proof of voluntary refusal of the test in the form of a signed statement by the Member's parent or guardian shall be documented in the Member's medical record. If the responsible party refuses to sign this statement, the refusal shall be documented in the Member's medical record. Documented attempts that demonstrate Physician's unsuccessful efforts to provide the blood lead screen test shall be considered towards meeting this requirement. [DHCS Contract, Exhibit A, Attachment III, § 5.3.4(D)]

67. Financial Viability. If Physician accepts financial risk for the provision of Covered Services, Physician will comply with CalOptima's system, Laws, and DHCS Contract's requirements to evaluate and monitor Physician's financial viability. [DHCS Contract, Exhibit A, Attachment III, § 3.1.6]

68. "Intentionally left blank"

69. "Intentionally left blank"

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ATTACHMENT H
DELEGATION AGREEMENT

For purposes of the Delegation Agreement (in this Attachment), Providence Medical Foundation, shall be referred to as "**Delegate**". Delegate agrees to perform the delegated services in accordance with the responsibilities outlined in this Attachment H for CalOptima and its Members assigned to Delegate.

This Attachment H shall supersede all prior delegation agreements between the Parties and remain in effect for the term of the Contract.

1. **Definitions**

   a. "**Standards and Requirements**" means currently applicable NCQA accreditation standards; DHCS, DMHC, CMS requirements; state and federal statutes, regulations, and sub-regulatory requirements; and CalOptima Policies and contractual requirements, including the State Contract.

2. **Delegate Obligations**

   a. **Standards and Requirements:** Delegate agrees (either itself or through a CalOptima-approved Subcontractor or downstream entity) to provide the delegated services set forth in Schedules A, B, C, D and E, as applicable, ("**Delegated Services**") in accordance with the terms of this Attachment H and Standards and Requirements. Delegate shall comply with new or revised Standards and Requirements from and after the effective date of any new or revised standard or rule. Changes necessary to comply with new/revised Standards and Requirements are not a change to a material term of this Attachment H requiring approval by either party.

   b. **Policies and Procedures:** Delegate shall comply with CalOptima's policies and procedures, including but not limited to CalOptima Policy GG.1619: Delegation Oversight. Delegate shall submit to CalOptima copies of Delegate's written policies and procedures for each delegated service as part of a readiness assessment and at least once each year during the term of the Contract. Delegate's policies and procedures are subject to annual review and/or review upon request by CalOptima.

   c. **Subdelegation:** Delegate agrees not to subdelegate any Delegated Services without prior written notice to, and approval by, CalOptima. Delegate shall provide CalOptima a written and complete list of subdelegates, vendors, subcontractors, and offshore entities performing services for or on behalf of Delegate at least sixty (60) days before the date Delegated Services are to begin, in accordance with CalOptima Policies. Delegate shall notify CalOptima, no later than sixty (60) days before any changes to the list of subdelegates, vendors, subcontractors, or offshore entities and/or or the movement of Delegated Services from one subdelegate or offshore entity location to another. CalOptima may audit Delegate's subdelegates with advance notice, and Delegate will ensure its contracts with Subcontractors and subdelegates provide such an audit right for CalOptima. All Delegate contracts with subdelegated entities shall require the subdelegated entity to perform all Delegated Service(s) in compliance with the Contract, including this Attachment H and all Standards and Requirements. Delegate is responsible for ensuring each subdelegate complies with the Standards and Requirements. Subdelegation shall not relieve Delegate of its obligations or liability under the Contract, including this Attachment H and its Schedules A, B, C, D and E (as applicable). Delegate represents and warrants that

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it shall take all steps necessary to cause subdelegates to comply with this Attachment H, including all applicable Schedules.

d. **Offshore Entities:** Delegate represents and warrants it does not and will not use any offshore entity to perform Delegated Services unless and until:

   i. Delegate provides sixty (60) days' advance written notice to CalOptima before entering into any agreement to subcontract any Delegated Service to an offshore entity;

   ii. CalOptima, in its sole discretion, agrees in writing to the subdelegation of Delegated Services to the offshore entity;

   iii. Delegate and offshore entity consent to and cooperate with CalOptima Policies and CalOptima's right to audit the offshore entity. Delegate shall also audit the offshore entity before the offshore entity's provision of Delegated Services and annually as long as Delegate subdelegates Delegated Services to the offshore entity; and

   iv. CalOptima and Delegate must file the proposed subdelegation of functions or services of the approved offshore entity with the appropriate regulatory authorities for approval and receive regulatory approval Delegate and the delegated offshore entity shall comply with any requirements that the applicable regulatory authority may issue at any time during the term of the Contract.

e. **Systems & System Conversions:** Delegate agrees to take all necessary steps to ensure the Delegate's systems perform in a manner that assures Delegate's compliance with all Standards and Requirements. Delegate shall provide CalOptima at least sixty (60) days' prior written notice of any systems conversions or modifications that directly impact its obligations under this Attachment H. All systems processing and/or storing of protected health information ("**PHI**") and/or personally identifiable information ("**PII**") must have at least one (1) system risk assessment/security review conducted annually that demonstrates to CalOptima that Delegate's administrative, physical, quality, and technical controls are functioning effectively in compliance with Standards and Requirements. Delegate agrees to cooperate with CalOptima and facilitate CalOptima's performance of any system risk assessment, security reviews, compliance, and/or system reviews, as required by law and its regulators.

3. **Delegate Representations and Warranties**

a. **Good Standing; Exclusion Lists:** Delegate represents and warrants to CalOptima that:

   i. Delegate is, and will remain throughout the Term of the Contract, in good standing under Standards and Requirements governing its existence and operations, and it is in compliance with and shall continue to comply with all laws and regulations applicable to this Attachment H and the duties and obligations under this Attachment H, including, but not limited to, Standards and Requirements related to Delegated Services (whether or not Delegate is directly obligated under or regulated by such Standards and Requirements);

   ii. Delegate is in compliance with any licensing requirements and agrees to maintain such compliance under Standards and Requirements for the express purpose of performing each delegated service; and

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iii. Neither Delegate nor any of Delegate's Subcontractors, as applicable, that are or will be fully or partially responsible for Delegate's performance of its obligations under this Attachment H have (A) pled guilty or no contest to or been convicted of any felony involving dishonesty or breach of trust; (B) been excluded from participation in any federal or state-funded health program; or (C) been listed in the Department of Health and Human Services Office of Inspector ("**OIG**") exclusion list or the General Services Administrative ("**GSA**") exclusion list. If the Delegate or any of Subcontractors or downstream entities, as applicable, are listed in the OIG or GSA exclusion lists after the effective date of the Contract, CalOptima shall have the right, in its sole discretion and judgment, to disqualify the listed person(s) from providing any part of the Delegated Services, or exercise CalOptima's rights to terminate Delegated Services under this Attachment H or to take other remedial steps.

b. **Program Representations:** Delegate warrants that each Delegated Service shall meet or exceed: (a) all CalOptima standards, policies, and procedures outlined in this Attachment H and CalOptima Policies, including the provider manual(s); (b) all Standards and Requirements applicable to Delegated Service; and (c)NCQA standards. In the event CalOptima or an accrediting organization's standards or any laws and regulations are materially changed or revised, Delegate agrees to comply with or implement, as applicable, and to the satisfaction of CalOptima, any such change or revision within the earlier of sixty (60) calendar days of receiving notice of such change or within such time frame as may be required by the accrediting organization, applicable laws and regulations, or CalOptima. The parties agree any such change or revision shall not be considered a change to a material term of this Attachment H, consistent with Section 2(a).

c. **Incentives:** Delegate further represents and warrants that as of the Effective Date and throughout the term of the Contract compensation, incentives or remuneration to persons performing such functions under this Attachment H shall not be based, directly or indirectly, on the quantity, frequency or percentage of or in any way relating to denials of Covered Services.

d. **Compliance - Government Programs:** Delegate shall (and shall cause its Subcontractors and downstream entities, as applicable) to institute, operate, and maintain an effective compliance program to detect, correct, and prevent the incidence of non-compliance with applicable state and federal regulatory requirements and the incidence of fraud, waste, and abuse. Such compliance program shall be appropriate to Delegate's, and, as applicable, Subcontractors' and any downstream entity organization's operations and shall include: (a) written policies, procedures, and standards of conduct articulating the entity's commitment to comply with Standards and Requirements, as well as providing mechanisms for employee/Subcontractor use in adhering to expectations regarding the reporting of potential non-compliance or fraud, waste, and abuse issues (internally and to CalOptima, as applicable); (b) for all officers, directors, employees, Subcontractors, agents, and downstream entities of Delegate, as applicable, required participation in effective compliance and anti-fraud training and education (this required training includes general compliance and fraud, waste and abuse training completion and code of conduct dissemination, initially within ninety (90) days of hire/contracting and at least annually after that; Delegate and Subcontractors and downstream entities, as applicable, may use

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CalOptima's code of conduct and training or an equivalent approved by CalOptima); and (c) processes to oversee and ensure compliance with these requirements.

e. **Notice of Adverse Action:** Delegate agrees to notify CalOptima promptly of: (a) any litigation brought against Delegate related to any Delegated Service or similar services provided by Delegate to other persons; (b) any actions taken or investigations initiated by any government agency involving Delegate or any entity in which Delegate holds more than a five percent (5%) interest; or (c) any legal actions or investigations, or notice thereof, initiated against Delegate by governmental agencies or individuals regarding fraud, abuse, false claim, or kickbacks. Upon CalOptima's request, Delegate agrees to provide all known details of the nature, circumstances, and disposition of any suits, claims, actions, investigations, or listings to CalOptima.

f. **Standard Operating Hours:** Delegate attests to standard operating hours for all contracted lines of business and all Delegated Services in this Attachment H.

4. **Rights and Obligations of CalOptima**

a. **Oversight:** Delegate agrees to allow and cooperate with CalOptima to maintain oversight of the Delegated Services, including, but is not limited to:

i. **Annual Audits:** Delegate shall allow CalOptima to conduct annual audits and/or review of Delegated Services upon thirty (30) calendar days' prior written notice or upon shorter notice in the event CalOptima determines a shorter period is necessary to ensure CalOptima or Delegate's compliance with Standards and Requirements. Cooperation with an annual audit shall include permitting CalOptima to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to delegated services performed by Delegate and any subdelegate, downstream or offshore entity, as applicable.

ii. **Corrective Action Plan:** If CalOptima has reason to believe Delegate failed to carry out a delegated service per the terms of this Attachment H or CalOptima's performance expectations, CalOptima will require the Delegate to submit, within a specified timeframe, a corrective action plan ("**CAP**") to address any compliance or other problems identified by CalOptima. Once the CAP is approved by CalOptima, Delegate will be required to implement, within ten (10) business days, or as designated by CalOptima, the approved CAP and permit increased audits of Delegate's performance to ensure compliance with such CAP. CalOptima may take further remediation actions as outlined in Section 15

iii. **External Audits:** Delegate shall allow and cooperate with CalOptima or CalOptima's designated agent(s), federal, state, and local governmental authorities having jurisdiction, and any applicable accrediting organization to audit, interview staff, and access view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services during regular business hours upon at least thirty (30) calendar days' prior written notice, or upon shorter notice if CalOptima determines a shorter period is necessary to ensure CalOptima's compliance with Standards and Requirements. Any such audit shall be permitted during the term of this Attachment H and for six (6) years thereafter (or longer if required by law),

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with Delegate and CalOptima responsible for their own expenses incurred related to such audit. This Section 4(a)(iii) shall survive the termination of the Contract, regardless of the cause of termination.

iv. **Onsite Monitoring:** Delegate shall permit and cooperate with CalOptima or CalOptima's designated agent(s), federal, state and local governmental authorities having jurisdiction, and any applicable accrediting organization to conduct routine and non-routine on-site visits and monitoring at any site at any time where the Delegate performs Delegated Services under the terms of this Attachment H with five (5) business days' advance notice for routine monitoring and one (1) day notice for non-routine monitoring (or upon shorter notice as required by Standards and Requirements). Cooperation with on-site monitoring shall include allowing CalOptima or CalOptima's designated agent(s), federal, state and local governmental authorities having jurisdiction, and any applicable accrediting organization, to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services.

v. **Accreditation Review:** Delegate shall permit and cooperate with NCQA to conduct on-site review of any documents related to services provided by Delegate under this Attachment H during a health plan accreditation survey of CalOptima by NCQA or other accrediting organization. Cooperation with such NCQA or other accrediting organizations, on-site review, and accreditation survey shall include permitting NCQA or other accrediting organizations to interview staff and access, view, copy (or receive electronic copies of) any requested files, policies, procedures, processes, decisions, documents, materials, and supporting systems related to Delegated Services.

vi. **Authority over Delegated Services:** CalOptima retains discretionary authority over all Delegated Services, including final decision-making and the operation thereof.

5. **Records and Confidential Information**

a. **Records:** Delegate agrees to retain Delegated Services records for the longer of ten (10) years following the date of service or the period required by Standards and Requirements. Delegate agrees to provide CalOptima or CalOptima's designated agent(s), federal, state, and local governmental authorities having jurisdiction, and any applicable accrediting organization, access to all delegated services records during regular business hours. This record retention provision (Section 5) shall survive the termination of the Contract regardless of the cause giving rise to the termination.

6. **Reporting:** Delegate shall provide Delegated Service reports via electronic submission to CalOptima's delegation oversight representative, as follows:

a. As outlined in the Schedules A, B, C,D and E, as applicable.

b. All other reports as required by CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting and the Report Binder.

c. CalOptima shall provide Member experience and Clinical Performance data to Delegate on an on-going basis. Member experience data shall be provided at least annually and

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include complaints, results of Member satisfaction surveys (such as CAHPS), and results of focused studies.

d. Delegate shall provide clinical performance data monthly or upon request and shall include HEDIS measure rates, HEDIS member-detail care gap reports, and other clinical data. Data shall be provided on Delegate's assigned secure file transfer protocol site.

7. **Conflicting or Overlapping Standards and Requirements:** If one or more regulatory or accreditation bodies have Standards or Requirements that create conflict or overlap, Delegate shall comply with the most stringent applicable Standards and Requirements for each Delegated Service. If Delegate is unsure of which standards may apply in a given situation, Delegate should contact healthnetworkdepartment@caloptima.org.

8. **Claims Payment Delegation:**

   a. Timely Adjudication of Claims:

      i. Delegate will process claims from and pay Providers in compliance with timeliness requirements outlined in Standards and Requirements, including, without limitation, California Health and Safety Code Section 1371, 28 CCR Sections 1300.71 and 1300.77.4.

      ii. For Medi-Cal Members, Delegate shall also comply with DHCS standards.

      iii. If Delegate delegates to a Subcontractor (*e.g.*, management company, claims administrator, subcontracted capitated provider) the obligation to process claims on Delegate's behalf, then Delegate shall: (A) notify CalOptima of such delegation in advance, and (B) require the Subcontractor to comply with the claims processing procedure requirements in this Attachment H and Standards and Requirements.

   b. **Claims Forwarding**: If Delegate receives a claim for services provided to a Member and the claim is the financial responsibility of CalOptima or another health plan, Health Network, or Provider, Delegate shall timely forward the claim to CalOptima or the applicable health plan, Health Network, or Provider within ten (10) working days pursuant to 28 CCR Section 1300.71(b)(3).

   c. **Failure to Make Payment:** Notwithstanding anything in this Attachment H, if Delegate fails to pay a Provider for Covered Services that are Delegate's financial responsibility under this Contract within the time frames outlined in this Attachment H and Standards and Requirements, (allowing for permissible disputes and appeals) and CalOptima reasonably determines that such amount is due and payable by Delegate, CalOptima may, after providing no fewer than ten (10) Business Days' prior written notice to Delegate, pay the amount due and deduct and offset such payment from any amount then or thereafter payable by CalOptima to Delegate.

9. **Utilization Management Delegation:** Delegate will maintain a well-structured and documented utilization management ("**UM**") program and will make UM decisions in a fair, impartial, and consistent manner, consistent with all Standards and Requirements, including CalOptima's UM program, and this Contract.

   a. Timely Decisions Made by Appropriately Licensed Professionals: Delegate will process UM requests in accordance with Standards and Requirements timelines for pre-

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service, concurrent, urgent, and post-service requests. The UM decisions will be made by appropriately licensed professionals and based upon all relevant clinical information.

b. **Member and Provider Notification:** Delegate will provide verbal, electronic and/or written UM denial notices to Members and treating Providers within Standards and Requirements timelines. Such notices will be written in using sixth (6^{th}) grade language, contain the specific protocol, benefit provision, and/or guideline that is the basis for denial, and include detailed instructions for appealing the UM decision. Further, Provider notices shall contain the name and direct telephone number, if available, or a general number and extension of the UM denial decision maker.

c. UM Information Integrity: At all times, during this Term, Delegate shall maintain detailed policies and procedures regarding UM information integrity that meet all Standards and Requirements. The Delegate's UM information integrity policies and procedures will (i) define how Delegate audits UM information for inappropriate documentation updates and implements corrective actions that address identified information integrity issues and (ii) describe how compliance with the information integrity policies and procedures is monitored and enforced.

10. **Credentialing Delegation:** Delegate will maintain a well-structured and documented credentialing program for evaluating and selecting licensed Providers to provide care to Members that comply with all Standards and Requirements and this Contract.

a. **Credentialing Committee:** Delegate will operate a Credentialing Committee comprised of Participating Providers that makes recommendations regarding credentialing and re-credentialing Providers. Delegate will further ensure that credentialing files received from Providers that meet established credentialing or recredentialing criteria are reviewed and approved by Delegate's medical director, designated physician, or Credentialing Committee.

b. **Timely Verification and Recredentialing:** Delegate will verify information using primary sources within; one hundred eighty (180) days of credentialing for files processed prior to July 1, 2025, and one hundred twenty (120) days of credentialing for files processed on or after July 1, 2025, or within a shorter timeframe if required by Standards and Requirements, to ensure Providers have the legal authority and relevant training and experience to provide quality care. Delegate will recredential Participating Providers within thirty-six (36) months of their prior credentialing/re-credentialing approval date.

c. **Actions Against Providers:** Delegate will maintain policies and procedures for taking actions against Providers for violations of applicable Standards and Requirements that include the range of actions available to the Delegate and how Delegate makes appeal processes known to Providers.

d. **Credentialing Information Integrity**: At all times during the Term, Delegate will maintain detailed policies and procedures regarding credentialing information integrity that meet all Standards and Requirements. The Credentialing integrity policies and procedures will (i) define how Delegate audits credentialing information for inappropriate documentation updates and implements corrective actions that address identified information integrity issues, and (ii) how compliance with these policies and procedures is monitored and enforced.

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e. **Final Network Determination:** CalOptima retains the right to approve, suspend, and terminate individual Practitioners, Providers, and sites from the Delegate's network relative to CalOptima's Medi-Cal program(s), even if CalOptima delegates credentialing and recredentialing decision-making to Delegate. CalOptima has the right to make the final determination of such participation in Delegate's network as it relates to CalOptima programs.

11. **Case Management Delegation:** Delegate will maintain a well-structured and documented case management program for members with multiple and/or complex health care conditions consistent with Standards and Requirements and this Contract.

    a. **Case Management Referral:** Delegate will have multiple referral avenues for Members and will accept referrals from sources including medical management, discharge planning, Members caregiver, and individual Practitioners. Delegate will begin the case management assessment process within thirty (30) days of referral to case management.

    b. **Case Management Process:** Delegate's case management process will address initial assessment of Member's health status, behavioral health status, daily living, and social determinants of health; evaluation of Member's needs, preferences, and limitations; and development of an individualized case management plan for each assigned Member, including ongoing communication strategies.

    c. **Case Management Systems:** Delegate will use a case management system that supports evidence-based, clinical guidelines to conduct assessment and management, automatic documentation of staff activity on case, and automated prompts for follow-up.

12. **Network Management Delegation**: Delegate will maintain an adequate network of primary care and specialty care practitioners and will monitor access and availability for its Members.

    a. Notification of Termination
        i. Delegate shall use information at its disposal to facilitate continuity and coordination of medical care across its delivery system.
        ii. Delegate shall notify Members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and help Members select a new practitioner.

    b. Continued Access to Practitioners
        i. If Delegate discontinues a contract with any practitioner, the Delegate shall allow affected Members continued access to the practitioner, in accordance with Laws and Standards and Requirements including the following:
            1. Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for Members undergoing active treatment for a chronic or acute medical condition.
            2. Continuation of care through the postpartum period for Members in their second or third trimester of pregnancy.

13. **Related Requirements**: Delegate will comply with all Standards and Requirements related to all Delegated Services, including, but not limited to:

    a. **New Provider Training**: Delegate will initiate training for all new Participating Providers no later than ten (10) business days from placing a Provider on active status in the network and shall complete the training within thirty (30) calendar days of placing a Provider on

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active status in the network. This training must include cultural and linguistic requirements, health inequities and identified cultural groups, and language and literacy needs.

14. **Regulatory Fines:** CalOptima and Delegate acknowledge that Delegated Services under this Attachment H are subject to regulation by governmental agencies with jurisdiction over the parties. If Delegate does not or is not able to fulfill any or all its obligations under this Attachment H, and if CalOptima is subject to any fines or fees from a governmental agency as a direct result thereof, Delegate agrees to pay to CalOptima the amount of such fines and any penalties incurred by CalOptima, including any applicable interest paid by CalOptima. CalOptima shall have sole discretion to pay such fees, fines, or penalties and/or to settle or compromise with such governmental agencies.

15. **Remediation for Delay or Failure to Implement CAP and/or Failures that May Cause Harm to Members:** If Delegate delays implementation of a CAP submitted and approved under Section 4(a)(ii), fails to complete a CAP within the timeframe specified in the CAP, or delegation failures that could jeopardize the health, safety, or welfare of Members, CalOptima may take any of the following remedial measures, in general order of escalation:

    a. Freeze Delegate Enrollment and/or Pause Auto-Assignment: CalOptima may freeze enrollment to the Delegate, through pausing auto-assignment of Members, or disallowing Member selection to the Delegate, or both.

    b. **Withhold Quality, Shared Savings, or Incentive Payments:** CalOptima may withhold or delay any applicable quality or other incentive payments or shared savings payments until the CAP is fully implemented or Delegate's failure is fully cured, as determined by CalOptima in its sole discretion.

    c. **Financial Penalties/Monetary Sanctions**: CalOptima may impose financial penalties/monetary sanctions if a Delegate fails to complete a CAP within the timeframe specified or demonstrates other failures impacting Member health, safety, or welfare:

        i. Per Member sanctions of $25,000 per Member:

            1. Delegate fails to provide medically necessary services that the Delegate is required to provide.
            2. Delegate inappropriately delays/denies Covered Services.
            3. Delegate fails to appropriately resolve a Member appeal consistent with Standards and Requirements.
            4. Delegate incorrectly charges premium or unnecessary out-of-pockets costs.
            5. Delegate inaccurately or untimely provides plan benefit information (*e.g.*, wrong denial notices).

        ii. Aggregate sanctions for failures that impact populations of Members

            1. One percent (1%) off the monthly capitation amount for a first violation.
            2. Two percent (2%) off the monthly capitation amount for a second violation.

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3. Three percent (3%) off the monthly capitation amount for each subsequent violation.

iii. Per determination: If CalOptima does not have the Member-specific data or the per Member impact cannot be clearly analyzed, CalOptima may calculate the penalty under the per determination basis.

iv. Delegate may appeal a financial penalty or monetary sanction through CalOptima's appeal process as outlined in CalOptima Policies.

d. **Use of a Monitor at Expense of Delegate:** In cases of continued non-compliance or failures that could jeopardize the health, safety, or welfare of Members, CalOptima may require the Delegate to engage and pay for an external auditor or other consultant acceptable to and approved by CalOptima, in order to correct the identified deficiency(ies) or areas of non-compliance, to CalOptima's satisfaction.

e. Modification of Delegation: If, for any reason, CalOptima or any state or federal governmental agency with jurisdiction is dissatisfied with the performance of the Delegated Services, CalOptima may, upon written notice to Delegate, modify Delegate's status (concerning all or a particular Delegated Service) from "fully delegated" to "delegated with corrective action." Such notice shall set forth the deficiencies perceived by CalOptima and/or any state or federal governmental agency in Delegate's performance of Delegated Services. If Delegate does not correct such deficiencies to the reasonable satisfaction of CalOptima and/or the governmental agency within ninety (90) days of such notice (or a shorter timeframe as determined by CalOptima in its reasonable discretion), CalOptima may, in its sole discretion, (a) extend the period given to Delegate to correct such deficiencies; (b) terminate all or any portion(s) of the delegation to Delegate; or (c) terminate this Attachment H.

f. Termination of Delegation with Notice: Notwithstanding Section 15e), CalOptima may, upon sixty (60) days' prior written notice to Delegate, terminate all or any portion(s) of the delegation to Delegate if, after consulting with Delegate, CalOptima or any state or federal governmental agency determines that Delegate (i) no longer meets all criteria for performance of the Delegated Service(s), or (ii) is not performing, or is not reasonably likely to perform, the Delegated Service(s) in full compliance Standards and Requirements. If, within such sixty (60)-day notice period, Delegate cures such deficiencies to CalOptima's reasonable satisfaction, CalOptima may withdraw such termination.

g. Immediate Termination of Delegation: Notwithstanding Sections 15(e) and 15(f) of this Attachment H, CalOptima may, upon prior written notice, immediately terminate all or any portion(s) of the delegation to Delegate of the delegated service(s) if, after consulting with Delegate, CalOptima or any Government Official reasonably determines that the continued performance of the Delegated Service(s) by Group would jeopardize the health, safety, or welfare of members assigned to Delegate under this Attachment H. Such de-delegation shall terminate when Delegate demonstrates to the satisfaction of CalOptima that members' health, safety, or welfare is no longer in jeopardy.

h. Material Breach: Delegate agrees that Delegate's failure to agree to or begin reasonable implementation of a CAP designed to correct identified deficiencies in Delegated Services under this Attachment H shall be considered a material breach of the Contract. Additionally, Delegate agrees that Delegated Services failures that could jeopardize the

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health, safety, or welfare of Members shall be considered a material breach of the Contract. Any such material breach of this Attachment H shall permit CalOptima to implement or engage in any or all oversight or other CalOptima rights and obligations described in the Contract, including under Section 13.

16. **Termination of Delegation (De-Delegation):** In the event CalOptima terminates delegation, or assumes all or any portion(s) of the Delegated Service(s) under this Attachment H, the following provisions shall apply:

    a. **CalOptima's Assumption of Payment of Claims:** If Delegate's claims procedures fail to comply with the obligations outlined in Schedule A of this Attachment H, CalOptima may, as required or permitted by Standards and Requirements, assume responsibility for the processing of claims that are Delegate's financial responsibility under this Attachment H. Such assumption may be altered to the extent Delegate has established and fully implemented an approved CAP consistent with California Health and Safety Code Section 1375.4(b)(4) and 28 CCR § 1300.75.4.8.

    b. **Capitation reduction for de-delegation:** Upon termination or assumption by a CalOptima of all or any portion(s) of a Delegated Service pursuant to this Attachment H, CalOptima may, in its sole discretion, reduce the net monthly Capitation Payment otherwise payable to Delegate by the percentage set forth below. Such amounts are not intended to represent the portion of the Capitation Payment allocated to cover the cost of performance of the Delegated Service(s) by Delegate nor an estimate of the costs incurred by CalOptima as a result of the termination of the delegation; rather, the amounts set forth below are intended as a performance fee for Delegate's failure to meet the standards established for performance of the Delegated Service.

	Medi-Cal
Utilization Management/ Case Management	3.0%
Credentialing	1.0%
Claims Processing	
- non-contracted only	1.0%
- all claims	7.0%
- non-contracted only payment withhold *	8.5%
- all claims payment withhold	85.0%

    * = Subject to actual claims paid experience.

    c. **Obligation to Cooperate:** Upon termination of the Contract for any reason, Delegate agrees to cooperate fully with CalOptima and comply with CalOptima procedures, if any, in the transfer of Delegate's obligations under this Attachment H to CalOptima or another CalOptima delegate. Delegate agrees to promptly provide CalOptima with any and all information and documentation necessary for such transfer. This shall include copies of all Delegated Services notes and accompanying records and information submitted by Providers as requested by CalOptima.

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Schedule A

Claims Payment Delegation

Delegated Claims Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Claims policies, procedures, and compliance	1. Annually submit updated, reviewed, and approved claims payment policies and procedures. 2. Provide oversight to any Subcontractors and subdelegated entities that perform claims processing or payment to ensure compliance with Standards and Requirements. 3. Submit all required reports and audit materials, as defined in Schedule A.	1. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 2. Review all required reports timely and provide substantive feedback.	Submitted to CalOptima's Delegation Oversight Committee ("Delegation Oversight") as part of the annual audit: 1. Updated, reviewed, and approved claims processing policies and procedures. 2. Evidence of oversight of Subcontractors and subdelegates	Annual audit, or more frequently as needed, using NCQA methodology for Medi-Cal Delegate must meet at a minimum 95% compliance for each LOB.	1. Corrective Action Plan (CAP) 2. Remediation steps outlined in Section 15
Claims processing	1. Identify and acknowledge electronic claims within two (2) working days of receipt. 2. Identify and acknowledge paper claims within fifteen (15) working days of receipt. 3. For Medi-Cal claims, process and adjudicate ninety percent (90%) of all Clean Claims for Covered Services within thirty (30) calendar days of receipt.	1. Annual claims audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements	Submitted via monthly XML process: 1. Claims XML Universe 2. Claims Universe Case Files 3. Claims Timeliness Report	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent	1. CAP 2. Remediation steps as outlined in Section 15

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Delegated Claims Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	4. For Medi-Cal claims, process and adjudicate ninety-nine percent (99%) of claims for Covered Services within ninety (90) calendar days after receipt. a.	for delegated activity. 3. Review all required reports timely and provide substantive feedback.	4. DHCS Post-Payment Recovery Report (Medi-Cal Only)	(95%) compliance	
Exclusion and preclusion monitoring	1. Verify Practitioner or Provider entity participation status prior to adjudicating any received claims as required by CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring 2. If Delegate pays a claim from an excluded Practitioner or Provider entity, Delegate must notify CalOptima, recover the payment, and prevent future payments to the excluded Provider.	1. Establish, interpret, and/or distribute Standards and Requirements for delegated activity.	1. Quarterly overpayment report outlined in reporting binder		1. CAP 2. Remediation steps as outlined in Section 15
Interest payment for late paid claims	Medi-Cal: 1. Pay interest and applicable penalties on all uncontested claims not paid within forty-five (45) business days. Interest shall begin to accrue on the forty-sixth (46th) business day following receipt of the claim and is calculated based on calendar days. 2. For emergency services, automatically include the greater of fifteen dollars ($15) for each twelve (12)-month period (or portion thereof) on a non-prorated			Annual audit, or more frequently as needed, using NCQA Methodology for Medi-Cal Delegate must meet at a minimum 95% compliance.	1. CAP 2. Remediation steps as outlined in Section 15

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Delegated Claims Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	basis, or interest at the rate of fifteen percent (15%) per year for the period of time the payment is late. 3. For late payments on all other claims other than complete claims for Emergency Services, interest at the rate of fifteen percent (15%) per year for the period of time the payment is late. 4. If Delegate fails to include the interest due on a late claim payment, the Delegate shall pay an additional ten-dollar ($10) penalty for that late claim, in addition to any interest amount due. a.				
Coordination of benefits	1. Have processes and procedures in place to identify payers that are primary and secondary to determine amounts payable and coordinate benefits for members with other health coverage ("OHC"), in accordance with Medicare and Medi-Cal crossover claims guidelines. 2. If a Member has OHC, consider the OHC plan as primary. 3. If a Member has both Medicare and OHC, both Medicare and OHC shall pay claims for services prior to Delegate. 4. Remain the secondary health plan and payer of last resort.	1. Annual claims audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity.	1. Monthly Post Payment Recovery Template	Policy review as part of annual audit	1. CAP 2. Remediation steps outlined in Section 15

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Delegated Claims Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	5. Identity and report to CalOptima any OHC or other private or public health insurance for Members 6. Identify and report to CalOptima any explanation of payment ("EOP") or explanation of medical benefits ("EOMB") received with other coverage payment	3. Review all required reports timely and provide substantive feedback.			
Third party liability	1. Notify CalOptima within five (5) calendar days of becoming aware of potential third-party liability (including casualty insurance, tort, workers compensation liability) related to Covered Services for a Member. 2. Make no claim for recovery of the value of covered services in an instance of Third Party Liability in which the DHCS has lien rights.	1. Annual claims audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	1. Report occurrences consistent with CalOptima Health Policy FF.2007: Reporting of Potential Third Party Liability	Policy review as part of annual audit	1. CAP 2. Remediation steps outlined in Section 15
Level 1 Provider	1. Acknowledge receipt of electronically submitted Level 1 disputes within two			Annual audit, or more	1. CAP

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Delegated Claims Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
dispute resolution	(2) working days; acknowledge receipt of hard-copy disputes within fifteen (15) business days after receipt of a complete provider dispute resolution. 2. Resolve Level 1 provider disputes or amended disputes related to claims payment decisions within forty five (45) business days after receipt of the provider dispute resolution request.			frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent (95%) compliance	2. Remediation steps outlined in Section 15

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Schedule B

Utilization Management Delegation

Delegated Utilization Management Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
UM Program policies, procedures, and compliance	1. Annually submit updated, reviewed, and approved written UM Program documentation outlining the structure, scope, responsible parties, criteria, timelines, policies, procedures, and processes that meet all Standards and Requirements. 2. Conduct an annual evaluation of the UM Program that verifies the program meets all Standards and Requirements, ensures all UM decisions are made by qualified professionals, evaluates the appropriateness of UM criteria, assesses the interrater reliability, ensures the criteria are consistently applied and available to Providers, and ensures all denials are reviewed by a physician or other appropriate professional. 3. Provide oversight to any Subcontractors and/or subdelegated entities that perform UM to ensure compliance with Standards and Requirements. 4. Submit all required reports and audit materials timely.	1. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 2. Review all required reports timely and provide substantive feedback.	Submitted via FTP: 1. Annual UM Program and Workplan 2. Semi-Annual Work Plan 3. Annual UM Evaluation 4. Annual UM Evaluation (Prior year) 5. All required documents for Annual Audit pursuant to the CalOptima Reporting Policy.	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal	1. CAP 2. Remediation steps outlined in Section 15

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Delegated Utilization Management Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
UM decision timeliness	Comply with all Standards and Requirements for notification of UM decisions, including CalOptima Health Policy GG.1508: Authorization and Processing of Referrals. Further, Delegate will make UM decisions in a timely manner and notify Providers and Members electronically or in writing: 1. Urgent concurrent and preservice decisions within seventy-two (72) hours of request 2. Medi-Cal non-urgent pre-service decisions within five (5) working days from receipt of information reasonably necessary to render a decision, but no longer than fourteen (14) calendar days from request. 3. Post-service decisions within thirty (30) calendar days of request	1. Annual UM Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	Submitted via monthly XML process: 1. Utilization Management (UM) XML Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 15
UM decision clinical information	1. Gather and use all clinical information relevant to the Member's care when making UM decisions 2. Adhere to policies set forth in CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines	1. Annual UM Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or	Submitted via XML: 1. Utilization Management (UM) XML Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum	1. CAP 2. Remediation steps outlined in Section 15

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Delegated Utilization Management Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.		ninety-five percent (95%) compliance	
Written notification of UM denials and appeal rights	Delegate shall comply with all Standards and Requirements for written notification applicable for Medi-Cal, including CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. Delegate shall use a readability scoring tool and ensure notices for Members do not use language exceeding a sixth (6th)-grade level. Further, written or electronic notification of UM denials for Members and Providers must include the following: 1. The specific reason for the denial in easily understood language. 2. A reference to the benefit provision, guideline, protocol or other similar criteria upon which the denial is based. 3. A statement that the Member can obtain a copy of the actual benefit	1. Annual UM Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	Submitted via XML: 1. Utilization Management (UM) XML Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 15

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Delegated Utilization Management Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	provision, guideline, protocol or other similar criteria on which the denial decision is based, upon request. 4. The Provider notice must be addressed to the requesting Provider (not organization) and include the name and direct telephone number, if available, or general number and extension of the decision maker 5. A description of appeal rights, including the right to submit written comments, documents or other relevant information. 6. An explanation of the appeal process, including Members' rights to representation and time frames 7. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials a. Timeframe for filing b. Timeframe for decision c. Process for expedited appeal, including where to direct appeal and what information to include 8. Notice that expedited external review can occur concurrently with internal appeals process for urgent care				

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Delegated Utilization Management Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
UM system controls (effective until June 30, 2025)	Delegate will maintain policies and procedures in its UM system controls that meet all NCQA requirements and: 1. Define date of receipt consistent with NCQA requirements 2. Define date of notification consistent with NCQA requirements 3. Describe process for recording dates in system 4. Specify titles/roles of staff authorized to modify dates once initially recorded and circumstances when modifications are appropriate 5. Specify how the system tracks: a. Date modifications b. When the date was modified c. Who modified the date. d. Why the date was modified. 6. Describe system controls to protect data from unauthorized modification 7. Describe how compliance with policies and procedures are monitored at least annually and how Delegate takes appropriate action when applicable 8. At least annually, monitors compliance with UM system controls by: a. Identifying and analyzing all modifications to dates that did not meet established policies and procedures. b. Acting on all findings and implementing a quarterly	1. Pre-delegation system review. 2. Annual review of delegate system policies and system control report. 3. Annual UM Program audits, or as often as necessary, and ongoing performance monitoring. 4. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 5. Review all required reports timely and provide substantive feedback.	All required documentation for annual audit pursuant to the CalOptima Health Reporting Policy HH.2003: Health Network and Delegated Entity Reporting, including the CalOptima Timely and Appropriate Submission Grid and Supplemental Attachment	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent (95%) compliance.	1. CAP 2. Remediation steps outlined in Section 15

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Delegated Utilization Management Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	monitoring process until improvement is demonstrated for one finding over three (3) consecutive quarters.				
UM Information Integrity (effective on and after July 1, 2025)	Delegate has UM information integrity policies and procedures, audits UM information for inappropriate documentation and updates and implements corrective actions that address identified information integrity issues: 1. The scope of UM information. a. UM requests from Members or their authorized representatives. b. UM request receipt date c. Appropriate practitioner review. d. Use of board-certified consultants. e. Clinical information collected and reviewed. f. UM decision. g. UM decision notification date. h. UM denial notice. 2. The Staff responsible for completing UM activities.	1. Pre-delegation system review. 2. Annual review of Delegate information integrity policies, training, audit and analysis report. 3. Review annual UM program audits, or as often as necessary, and ongoing performance monitoring. 4. Establish, interpret, and/or distribute Standards and Requirements	All required documentation for annual audit pursuant to the CalOptima Health Reporting Policy HH.2003: Health Network and Delegated Entity Reporting, including the CalOptima Timely and Appropriate Submission Grid and Supplemental Attachment.	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal	1. CAP 2. Remediation steps outlined in Section 15

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Delegated Utilization Management Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	a. For documenting the completion of UM activities, authorized to modify UM Information and oversight of UM information integrity functions, including auditing. 3. The process for documenting updates to UM Information. a. Specify when updates to existing UM information is appropriate b. Describe the Delegate process for documenting the following when updates are made to UM information. Staff who updated the information, when, what and why the information was modified. 4. Inappropriate documentation and updates with falsifying credentialing information. 5. Audits UM staff and the process for documenting and reporting identified information integrity issues. 6. At least annually train UM staff on: a. Inappropriate documentation and updates and updates, annual audits and process for documenting and reporting	for delegated activities. 5. Review all required reports timely and provide substantive feedback.			

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Delegated Utilization Management Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	inappropriate documentation and reporting consequences. 7. At least annually audits and analyzes for inappropriate documentation and updates to UM denial receipt and notification dates and conduct qualitative analysis. 8. Improvement Actions: a. Delegate implements actions to address all inappropriate documentation and updates found during the audit. b. Conducts and audits the effectiveness of corrective actions on the findings 3-6 months after completion of the annual audit, if applicable.				
Level 1 Provider dispute resolution	1. Process and resolve Level 1 Provider disputes related to post-service UM decisions according to Standards and Requirements, including CalOptima Policies	1. Annual audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements	Submitted via XML: 1. UM Retrospective Post-Service Decision Universe	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent	1. CAP 2. Remediation steps outlined in Section 15

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Delegated Utilization Management Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		for delegated activity. 3. Review all required reports timely and provide substantive feedback.		(95%) compliance	

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Schedule C

Case Management Delegation

Delegated Case Management Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Case management activities	1. [List of CM activities delegated as of date of the Attachment H] 2. Changes necessary to comply with new/revised Laws and Standards and Requirements will not be considered a change to a material term of this Attachment H requiring approval by either party	1. [List of CM activities retained by CalOptima]	N/A	N/A	N/A
Case management policies, procedures, and compliance	1. Annually submit updated, reviewed, and approved written Case Management ("CM") program documentation outlining the structure, scope, responsible parties, criteria, timelines, policies, procedures, and processes that meet all Standards and Requirements. CM program shall include basic care management, care coordination, complex care management services, and transitional care services. The CM program shall include care management , EPSDT, children with special health care needs, early intervention services, care transitions, and whole-child model. 2. Conduct an annual evaluation of the CM program that verifies the program meets all Standards and Requirements, ensures the appropriate identification,	1. Pre-delegation reviews. 2. Annual CM program audits, or as often as necessary. 3. Quarterly case file audits. 4. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 5. Review all required reports timely and	All required documentation for CM program annual audit Submitted via FTP: 1. Monthly Case Management Log 2. Quarterly case files as identified by CalOptima	Annual policy review or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet ninety-five percent (95) Quarterly case file review Delegate must meet minimum of 75% compliance	1. CAP 2. Remediation steps outlined in Section 15

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Delegated Case Management Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	stratification, and management of members. 3. Provide oversight to any subdelegated entities, vendors, or consultants that perform CM to ensure compliance with Standards and Requirements. 4. Submit all required reports and audit materials timely.	provide. substantive feedback if appropriate.		for two consecutive quarters. Score is the combined percentage of each audited case across all applicable line of business	
Case management program referral	Delegate identifies Members with multiple or complex health care conditions, obtains access to care, and coordinates their care. Delegate has multiple referral programs (including but not limited to): 1. Medical management 2. Discharge planning 3. Member or caregiver 4. Practitioner	1. Pre-delegation reviews. 2. Conduct quarterly case file reviews or as often as necessary. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive	Submitted via FTP: 1. Monthly Case Management Log 2. Quarterly case files as identified by CalOptima	Quarterly case file review, or more frequently as needed, using NCQA Methodology Delegate must meet minimum of 75% compliance for two consecutive quarters. Score is the combined percentage of	1. CAP 2. Remediation steps outlined in Section 15

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Delegated Case Management Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		feedback if appropriate.		each audited case across all applicable line of business.	
Case management systems	Delegate uses a CM system that supports: 1. Evidence-based clinical guidelines to conduct initial assessment and ongoing management. 2. Automatic documentation of date, time and individual who takes action on a case or interacts with a Member. 3. Automated prompts for follow-up	1. Pre-delegation reviews. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity.	All required documentation for CM program annual audit		1. CAP 2. Remediation steps outlined in Section 15

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Schedule D

Credentialing Delegation

Delegated Credentialing Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Credentialing policies, procedures, and compliance	Annually, Delegate will submit updated, reviewed, and approved written Credentialing Program documentation outlining the credentialing process for evaluating and selecting licensed Providers to provide care to Members that comply with all Standards and Requirements and CalOptima contract provisions. The program documentation must specify: 1. Types of Providers to credential and recredential. 2. Verification sources. 3. Criteria for credentialing and recredentialing. 4. Process for making credentialing or recredentialing decisions. 5. Process for managing credentialing files that meet the Delegate's criteria. Effective July 1, 2025, the process for managing credentialing must also include files that do not meet the organization's criteria. 6. Effective July 1, 2025, and after, the Delegate must identify the criteria for practitioner sanctions, complaints and other adverse events found during ongoing monitoring that need to be reviewed by the credentialing	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity 4. Review all required reports timely and provide substantive feedback.	Submitted to Delegation Oversight annually via the audit process: 1. Credentialing program documentation	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 15

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Delegated Credentialing Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	committee or other designated peer-review body. 7. Non-discrimination credentialing policies and procedures. 8. Delegate must identify the process for notifying practitioners if information obtained during the credentialing process varies from what was provided. 9. Prior to July 1, 2025, Delegate must identify a process for notifying practitioners of the credentialing and recredentialing decision within sixty (60) calendar days from the Credentialing Committee's decision,. Effective July 1, 2025, the credentialing and recredentialing decision must be done within thirty (30) calendar days. 10. Roles and direct responsibility of Delegate's Medical Director or other designated physician in the Credentialing Program. 11. Confidentiality policies and procedures. 12. Policies and procedures designed to ensure accuracy of provider directories to include the highest level of education, training, board certification and specialty. 13. Effective July 1, 2025 and after, Delegate must have a process for documenting information and activities				

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Delegated Credentialing Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	in credentialing files. Using either of the following methods or a combination: a. Credentialing documents signed (or initialed) and dated by the verifier b. A checklist that includes, for each verification, the source used, date of verification, signature or initials of the person who verified the information, and report date, if applicable. c. A checklist with a single signature and a date for all verifications that includes a statement confirming that the signatory verified all credentials on that date and that includes for each verification source used and report date, if applicable. 14. Delegate will notify Practitioners about their right to review information about their application, correct errors, and check status of the application. 15. How Delegate considers Provider performance during recredentialing, including but not limited to, Member complaints/grievances.				

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Delegated Credentialing Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	16. For the Medicare LOB, ensure participating physicians haven't opted out of Medicare. 17. For the Medi-Cal LOB, ensure all Providers are confirmed as screened and enrolled for participation in Medi-Cal where there is an enrollment pathway. 18. Prohibit employment or contracting with practitioners or organizational providers (or entities that employ or contract with such practitioners or organizational providers) that are excluded/sanctioned from participation in Medicare or Medi-Cal or are excluded on any other state or federal exclusion, sanction, restriction or preclusion list. 19. Demonstrates compliance with CalOptima policies regarding credentialing all provider types GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment and Reassessment of Organizational Providers.				
Credentialing Committee	Delegate will operate a Credentialing Committee that makes recommendations regarding credentialing and re-credentialing decisions: 1. Committee is comprised of Participating Providers.	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and		Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal	1. CAP 2. Remediation steps outlined in Section 15

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Delegated Credentialing Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	2. Reviews credentials for Providers who do not meet thresholds established by the Committee. 3. Ensures that files that meet Credentialing Committee-established criteria are reviewed and approved by Delegate's Medical Director, designated physician, or Credentialing Committee.	ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide substantive feedback.		Delegate must meet at a minimum ninety-five percent (95%) compliance	
Organizational Providers	The Delegate shall assess and approve, initially and in an ongoing manner, Provider organizations. Before the Delegate contracts with an organizational Provider, and for at least every thirty six (36) months thereafter, it: 1. Confirms that the Provider is in good standing with state and federal regulatory bodies. 2. Confirms that the Provider has been reviewed and approved by an accrediting body. 3. Conducts an onsite quality assessment if the Provider is not accredited.	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements		Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 15

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Delegated Credentialing Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	4. Ensures that the Provider is Medi-Cal enrolled, if an enrollment pathway exists.	for delegated activity. 4. Review all required reports timely and provide substantive feedback.			
Verification of credentials	Delegate will conduct timely verification within one hundred eighty (180) days of credentialing of information (or a shorter time frame as required by Standards and Requirements) to ensure Providers have the legal authority and relevant training and experience to provide quality care to Members. Delegate will verify credentialing information through primary sources, unless otherwise indicated. Effective July 1, 2025, Delegate will conduct timely verification within one hundred twenty (120) days of credentialing of information. 1. All National Provider Identifier (NPI) numbers, where applicable 2. A current and valid license to practice 3. A valid DEA or CDS certificate, as applicable (Prior to the credentialing decision) 4. Education and training, consistent with Standards and Regulations (Prior to the credentialing decision)	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	Submitted via FTP: 1. Credentialing Universe is sent Bi-Annually 2nd of March and September	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 15

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Delegated Credentialing Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	5. Board certification status, as applicable 6. Work history (180 calendar days) • The 180-calendar-day verification time limit applies to files processed by the delegate on or after July 1, 2025. Files processed before July 1, 2025, are scored against the previous verification time limit requirement of 365 calendar days 7. History of professional liability claims that resulted in settlements or judgements paid on behalf of practitioner 8. For Sanction information, Delegate must use State Medicaid Agency and one of the following: a. Office of Inspector General (OIG) b. System for Award Management (SAM) c. Medicare Opt-Out, if applicable d. Medi-Cal Suspended & Ineligible List e. CMS Preclusion List f. DHCS Medi-Cal Restricted Provider Database 9. For exclusions, Delegate must use both of these sources:				

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Delegated Credentialing Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	a. List of Excluded Individuals and Entities (LEIE) issued by OIG b. State Medicaid Agency 10. For Medi-Cal LOB: For primary care Practitioners, the Delegate will obtain evidence of passing the DHCS Facility Site Review prior to the credentialing date. FSR must be no older than thirty-six (36) months at the time of the credentialing decision date, as applicable. 11. For Medi-Cal LOB: Delegate shall verify enrollment into the Medi-Cal program. Verification information located at https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers.				
Credentialing applications	Delegate will require Providers to submit a credentialing/re-credentialing application that includes a signed attestation that includes: 1. Reasons for inability to perform the essential functions of the position. 2. Lack of present illegal drug use 3. History of loss of license and felony convictions 4. History of loss or limitation of privileges or disciplinary actions 5. Current malpractice insurance coverage	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements		Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps as outlined in Section 15

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Delegated Credentialing Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	6. Effective July 1, 2025, and after, the application must include practitioner race, ethnicity, and language. The application must inform practitioners this information is optional and that the Delegate does not discriminate, penalize or base credentialing decisions on this information. 7. The application's accuracy and completeness 8. Hospital admitting privileges at a CalOptima contracted Hospital or if Delegate is financially responsible for Hospital services, a Delegate-contracted Hospital 9. Practice coverage, including names of answering service and covering physicians	for delegated activity. 3. Review all required reports timely and provide substantive feedback.			
Recredentialing cycle	1. Delegate will recredential Participating Providers within thirty-six (36) months of their prior approval date. 2. In between recredentialing cycles, Delegate will perform ongoing monitoring and interventions between recredentialing cycles and take appropriate action against Providers when Delegate identifies occurrences of poor quality. Monitoring shall include collecting and reviewing: Medicare and Medi-Cal/Medicaid sanctions or	1. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and	Submitted via FTP: 1. Credentialing Universe is sent Bi-Annually 2nd of March and September	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent	1. CAP 2. Remediation steps as outlined in Section 15

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Delegated Credentialing Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	limitations on licensure, complaints, and information of adverse events. 3. Re-credentialing must include documentation that Delegate has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, Member grievances, and medical record reviews.	Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.		(95%) compliance	
Ongoing Monitoring and Interventions	Delegate has a process in place to monitor practitioners between credentialing cycles using the following: 1. Medicare and Medicaid sanctions using State Medicaid Agency and one of the following sources: For sanctions, it is a. AMA Physician Master file b. Federation of State Medical Boards (FSMB) c. National Provider Data Bank (NPDB) d. SAM 2. Medicare and Medicaid exclusions using both of these sources: a. List of Excluded Individuals and Entities (LEIE) issued by OIG b. State Medicaid Agency 3. July 1, 2025, and after, sanctions, limitations and expiration on licensure using at least one of the following sources: a. NPDB	1. Annual credentialing program audits, or as often as necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.		Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps as outlined in Section 15

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Delegated Credentialing Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	b. FEHB c. State agencies d. FSMB e. State licensure or certification board 4. Practitioner-specific Member complaints and evaluates practitioner's history of complaints 5. Adverse events at least monthly a. Investigates all practitioner complaints upon their receipt and evaluates the practitioner's history of complaints, if applicable and b. Evaluate the history of all complaints for all practitioners at least every 6 months Delegate must have criteria in place to determine issues to be taken to its credentialing committee arising from these five areas listed above and provide evidence of reporting to the credentialing committee				
Actions against Providers	1. Delegate has policies and procedures for taking actions against Providers that include the range of actions available to Delegate and how it makes appeal processes known to Providers. These policies and procedures establish that the majority of the appeal panel are	1. Annual Credentialing Program audits, or as often as necessary, and ongoing	1. Delegate must report any Business & Professions Code §§ 805 and/or 805.01 actions immediately to	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal	1. CAP 2. Remediation steps outlined in Section 15

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Delegated Credentialing Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	peers of the Provider in question, and prohibit Delegate from attorney representation at appeal hearings unless the Provider is also represented. 2. If Delegate takes action against a Provider for quality reasons, Delegate will report the action to the appropriate authorities and offers a formal appeal process. 3. Delegate will use objective evidence and patient care considerations to decide on altering a Provider's relationship with Delegate if the Provider doesn't meet Delegate's quality standards.	performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.	CalOptima Quality Improvement Department at MyCredentialingUpdates@caloptima.org	Delegate must meet at a minimum ninety-five percent (95%) compliance	
Identification of HIV/AIDS Specialists	Delegate has policies and procedures for identifying HIV/AIDS Specialists: 1. Documentation describes how the Delegate identifies and annually reconfirms appropriately qualified physicians who meet the definition of an HIV/AIDS Specialist, according to California regulations. 2. Documents that Delegate provides list of qualified Specialists to Delegate's department responsible for authorizing standing referrals	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements		Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 15

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Delegated Credentialing Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
		for delegated activity. 4. Review all required reports timely and provide substantive feedback.			
Credentialing System Controls (effective until June 30, 2025.)	Delegate has policies and procedures in its Credentialing Program system controls that meet all NCQA requirements and: 1. How primary source verification information is received, dated and stored. 2. How modified information is tracked and dated from its initial verification. a. When modified b. How modified c. Who modified d. Why modified 3. Identifies staff who are authorized to review, modify and delete information and circumstances when modification or deletion is appropriate. 4. Security controls in place to prevent unauthorized modification. a. Limiting physical access to location that houses credentialing information b. Preventing unauthorized access, changes to, and release of credentialing information	1. Pre-delegation reviews. 2. Annual Credentialing Program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 4. Review all required reports timely and provide	1. Annual report on monitoring of system controls	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 15

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Delegated Credentialing Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	c. Password-protecting electronic systems, including user requirements, to prevent passwords from being compromised and policies and procedures regarding changing or withdrawing passwords if compromised passwords or individuals should no longer have electronic access to the system 5. How Delegate monitors its compliance with its Credentialing System Control policies and procedures at least annually and takes appropriate action when applicable.	substantive feedback.			
Credentialing Information Integrity (effective on and after July,1, 2025)	Delegate has credentialing information integrity policies and procedures, audits credentialing information for inappropriate documentation and updates and implements corrective actions that address identified information integrity issues: 1. Delegates policies specify protection of each of the following types of credentialing information: a. The practitioner application and attestation b. Credentialing documents received from the source or agent,	1. Pre-delegation reviews. 2. Annual credentialing program audits, or as often as necessary, and ongoing performance monitoring. 3. Establish, interpret, and/or distribute Standards and Requirements	All required documentation for annual audit pursuant to the CalOptima Health Reporting Policy HH.2003: Health Network and Delegated Entity Reporting, including the CalOptima Timely and Appropriate Submission Grid and Supplemental Attachment	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 15

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Delegated Credentialing Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	c. Documentation of credentialing activities d. Credentialing committee minutes e. Documentation of clean file approval, if applicable. f. Credentialing checklist, if used. 2. The staff responsible for performing credentialing activities: a. For documenting credentialing activities, authorized to modify credentialing information and oversight of credentialing information integrity functions. 3. The process for documenting updates to credential information. a. Specify when updates to existing credentialing information is appropriate b. Describe Delegate's process for documenting the following when updates are made to credential information. Staff who updated the information, and when, what and why the information was modified. 4. Inappropriate documentation and updates with falsified credentialing information.	for delegated activities. 4. Review all required reports timely and provide substantive feedback.			

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Delegated Credentialing Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	5. Audits credentialing staff and the process for documenting and reporting identified information integrity issues. 6. At least annually train CR staff on: a. Inappropriate documentation and updates, annual audits, and process for documenting and reporting inappropriate documentation and reporting consequences. 7. At least annually, Audits and Analyses: a. For inappropriate documentation and updates to credentialing information and conduct qualitative analysis. 8. Improvement Actions: a. Delegate implements corrective actions to address all inappropriate documentation and updates found during the audit. b. Delegate conducts an audit of the effectiveness of corrective actions on the findings 3-6 months after completion of the annual audit.				
Subdelegation of credentialing	If Delegate subdelegates (subject to CalOptima's prior written approval) credentialing functions to another entity, Delegate will perform oversight of the	1. Annual Credentialing Program audits, or as often as		Annual audit, or more frequently as needed using	1. CAP 2. Remediation steps as

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Delegated Credentialing Activity	Delegate Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
	subdelegated relationship in accordance with all Standards and Requirements, including but not limited to: 1. Using a written delegation agreement including all Standards and Requirements 2. Performing a pre-delegation review prior to implementation of Contract, including credentialing information integrity. 3. Requiring at least semi-annual reporting 4. Having a described process Delegate will use to evaluate subdelegated entity's performance 5. Describing to subdelegate remedies available to Delegate if subdelegate does not fulfill its obligations 6. Identify and follow-up on opportunities for improvement, if applicable.	necessary, and ongoing performance monitoring. 2. Establish, interpret, and/or distribute Standards and Requirements for delegated activity. 3. Review all required reports timely and provide substantive feedback.		NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent (95%) compliance	outlined in Section 15

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Schedule E

Network Management Delegation

Delegated Network Management Activity	Delegated Responsibility	CalOptima Responsibility	Reporting	Performance Evaluation	Remediation
Notification of Termination	Delegate uses information at its disposal to facilitate continuity and coordination of medical care across its delivery system. Delegate notifies Members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective termination date, and helps them select a new practitioner.	1. Annual Audits or as often as necessary and ongoing monitoring.	Submitted via FTP Site: 1. Provider Termination Quarterly Report	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 15
Continued Access to Practitioners	If a practitioner contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: 1. Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition. 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy	1. Annual Audits or as often as necessary and ongoing monitoring.	Submitted via FTP Site: 1. Provider Termination Quarterly Report	Annual audit, or more frequently as needed using NCQA methodology for Medi-Cal Delegate must meet at a minimum ninety-five percent (95%) compliance	1. CAP 2. Remediation steps outlined in Section 15

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